Division of Mental Retardation and Developmental Disabilities

Positive Behavior Support Guidelines

Revised March 2008

Table of Contents

Table of Contents Cont.

Acknowledgments

Section I. Introduction

This book attempts to move from previous philosophies and theories on behavior, usually called behavior management, to a philosophy called positive behavioral support, which is more in accordance with the [Missouri Quality Outcomes](#) and current best practice standards. These serve as a guiding philosophy for providing services and supports for all people who have developmental disabilities, including those with challenging behaviors.

Historically, we have used behavioral techniques in working with people with developmental disabilities to eliminate behavior we perceived as disruptive or undesirable. In some cases physical interventions, such as physical restraints, were utilized or even chemical restraints (sedative medication). We now see several areas in which our practices can, and must, be improved.

One area concerns the logic we use in deciding which behaviors we should intervene to change. This book attempts to provide some guidance in how we should decide whether we have the right to intervene to change the behavior of another person, and when we have the obligation to do so. We must recognize that persons with disabilities want control over their own lives and that they have rights we cannot and should not take away except under the most extreme of situations. Our job is to help them achieve the control they desire, and are legally entitled to, in the most responsible way we can.

A second area of improvement concerns our understanding of behavior itself. We know now that undesirable behavior can often be understood only by looking at the broad context of the person's life. Focusing solely on the undesirable behavior itself may cause us to overlook the underlying factors causing the behavior. In the vast majority of cases, disruptive behavior is communicating something. <u>We must learn to listen.</u> **We must also continually question the ethics and humanity of our methods and thought processes.**

Finally, although this is not an exhaustive list of areas of improvement, we now know that the more respectful we are of the individual and the gentler we are in our approaches, the more responsive people tend to be to our efforts to support their behavior change.

As used throughout the book the term "we" includes all staff of the Division and provider agencies working together to support people who have developmental disabilities. When we refer to people who use supports, we use the terms "individuals", "persons", and "people who have developmental disabilities". It is also worth noting that although many people who have a developmental disability do not have any cognitive impairment, the examples in this book are in general written to describe situations of persons who do.

Purpose

This book provides guidance for using behavioral supports which will:

- Help the person learn effective behaviors which will assist them in reaching their own personal goals;
- Help the person learn to make responsible personal choices by helping them to learn how to become responsible and
- Minimize behaviors that put the individual and others at physical risk.

Good behavioral support helps people learn useful skills and gives them more control over their own lives. Bad behavior programs simply coerce behavior change and continue an old system where *we* impose our wishes on people with developmental disabilities. There is no substitute for getting to know the individual as a person. Many of the strategies which are described in this book require hard work, commitment, and caring on a personal level from staff. Implementation will also require further study, training and information gathering. Although not initially considered a behavior support strategy, person-centered planning processes became a part of positive behavior support approaches over a decade ago because researchers and practitioners began to realize that person-centered planning approaches could establish and enhance a positive behavior support approach (Kincaid,1996). Since then, person-centered planning has had a profound impact on how positive behavior support approaches are delivered in homes, schools, and communities (Kincaid & Fox, 2001). Therefore, it is vital that individuals providing positive behavior supports are trained in person-centered planning.

Division Philosophy

While each facility and agency is unique in some respects, there should be general philosophical agreement on ways to support people who have developmental disabilities and what to do in emergency situations. We believe that policy and practice in the area of behavioral support must:

- Stem from a strong, person-centered value base which places dignity and respect for the person at its core;
- Shift the emphasis from applying techniques to understanding the person in the context of their life, and helping them attain a life that they value;
- Ensure that any attempt to alter behavior must be coupled with earnest protection of the person's constitutional, statutory and human rights and;
- To do all of the above with the intention to improve the quality of life for the individual and gentle actions that absolutely minimize the need for any restrictive, punitive, or physical interventions, such as restraints or enforced compliance.

A framework for Positive Behavioral Supports is the "Arch". The "Arch" diagram you will find in this section illustrates how various concepts fit together in supporting a person. It is the responsibility of all who support individuals to: *know the person*, *plan*, and *take action*. The building blocks of the "Arch" must rest on a foundation of knowing the person with a keystone to hold the Arch principles together. The keystone is self-determination, the ultimate goal.

The Arch Diagram

Communication

Learning new and positive ways to get what you want

Self-Determination

Create a Positive Environment

Opportunities for Quality of Life

Making best guesses about what we have learned about people

Knowing People's skills and talents

Discovering what motivates people

Our Teaching Ability

Understanding why people do the things they do

Our attitudes sensitivity

Functional Assessment/ Information Gathering	Person-Centered Planning	Action Planning/ Taking Action

Knowing the person

Building Blocks to Self-Determination

Understanding Why People Do the Things They Do

To support others in learning the skill of self-determination, individuals must be well able to listen to and understand human behavior. Comprehending the underlying functions of human behavior is critical to being able to adequately understand others. **It must be understood that all human behavior is purposeful and goal-oriented, although the purposes or goals of each behavior may not be readily perceived.** In fact, it is quite common to misperceive another's purpose or goal. Understanding the many factors which influence human behavior and the way that behavior generally tends to present itself will guide one into greater understanding of others. The learner can begin to "listen" not only to words and body language, but to the actual behaviors themselves, for the "message" behind those behaviors.

Discovering What Motivates People

When we discover what motivates people, we can support them in pursuing those activities. Supporting people in what they want to do is what self-determination is all about. When people can do what they like, they are happier and have greater self-esteem. They can learn self-control.

> **"***To have meaning, find your passion and pursue it.***"**

An essential feature of discovering what motivates each and every person is to understand and honor the person's natural and preferred routines and rhythms of life. This includes things like finding out how the person likes to structure their waking-up routines in the morning.

Making Best Guesses About What We Have Learned About People

To support others in learning the skill of self-determination, we need to be able to hypothesize about the function of a given problem behavior. We rely on help from other qualified persons when assistance or advice is needed about problem behaviors. It is helpful to remember that changes in behavior, especially sudden changes, may have a physical origin, so health issues should be considered. Protection of health and safety of the individual and others should be the first consideration during examination of problem behaviors. During this phase of developing better understanding of the person, it is important to have an emergency backup plan, should the behaviors worsen.

After these factors have been addressed, it may be time to problem solve about the cause (communication/meaning) of a problem behavior, and how to create opportunities for the behavior to change.

Communication

Communication refers to <u>all</u> the ways we express and receive information. It is often difficult to understand what a person is trying to tell us, especially if they cannot or do not use words. <u>It is a primary responsibility to make sure the person supported is able, *through some means*, to communicate with those around them.</u> This can be done by utilizing some form of communication technology, such as a communication board. Or it can be done by making sure the person is surrounded by people who understand their communication cues, or behaviors. This is a crucial part of the person-centered plan and should be addressed in a systematic manner.

Communicating is much more than talking. Focusing only on the exchange of words does not ensure that understanding will follow. To begin understanding, the focus must be on the person. We must realize there are many methods for communicating one's needs, wants and desires. The person's behavior represents a powerful method of communication.

Learning New and Positive Ways to Get What You Want

It is important to remember that behavior is motivated by something; behavior is functional. To substitute a non-desirable behavior with one that is more desired, the new behavior must have the same outcome for the person. The new behavior must be such that it is functionally equivalent to the old non-desired behavior, and be just as easy to use for the person. We ethically cannot remove a functional behavior from a person without teaching an alternative that will be just as successful for the person. That means that if the undesired behavior has proven to be an effective communication tool (such as a way of communicating, *I am frustrated and I want to stop this activity now*, or *I don't like it when you do that*), we are obligated to teach the person another way to get what they want that is just as quick and effective. Sometimes, the staff (or even family) around the person may not actually realize that the person's unpleasant or disruptive behavior is achieving some desired outcome for the person.

Our Attitudes

Attitude: A position or manner indicative of feeling, opinion, or intention toward a person or thing. -- Webster's Dictionary

Our values and attitudes can influence, or even determine, how persons are perceived. Over the years, various labels have been used to classify people with disabilities. Labels tend to take on negative meanings and images that demean and stereotype people with disabilities. This further emphasizes differences, rather than highlighting individuality and abilities. Labels can close off our thinking and cause us to make predictions about people, based only on

our prejudiced assumptions about what they can or cannot do. This leads to lower expectations, restricted lifestyles, intrusive "programs", negative images, limited access and isolation.

Our attitude may also influence how a person is supported in his community, therefore shaping the day-to-day life of someone with a disability. Historically, people who have developmental disabilities have often been observed living, working or participating in recreation together. This reinforces a tendency for society to think of "them" as a group, not as individual people. What do we think when we see a group of people with disabilities shopping in a department store, for example, with a staff person? As a group, they may be seen as "different". When people are always grouped together it makes it difficult for others to see each person as a unique individual. Communities are for everyone!

Many of us have had the opportunity to discover that people with disabilities can contribute to our lives as friends, co-workers, teachers and neighbors. Higher expectations are created once we get to know people as "people first". Our attention shifts from the person's deficits to what the person can contribute and accomplish. We begin to reshape our roles from caretaker to support person. We begin to focus on choice rather than control. To have a quality of life, we all need self-respect, and the respect of others. We must remember that because a person relies on us for support does not change the fact that the person is capable – more like you than different.

Power Struggles

The truth is that there are just some people we do not get along well with. For many of us it seems there is nothing worse than having a "boss" who doesn't seem to like us. Then there are those people who just seem to enjoy making us miserable – hassling us one way or another at every turn. If you are a person who has a developmental disability, then you know that much of your safety, health, security, and even happiness, can depend on these people called "staff" – some of whom behave in the ways described above. These interactions affect our thinking, our feeling, and thus, our behaving. We need to look closely at any staff interaction that could be a potential source of problems.

Finally, on the issue of power struggles: **Just don't do it!** It is amazing how often people with disabilities must contend with staff who feel the need to show how much "authority" they have – how much power they possess over the lives of people who have disabilities.

If we are truly involved in caring relationships that are gentle in intent, based in dignity and respect, then there is no acceptable reason for power struggles. What every person "needs" is to be treated as they deserve to be treated.

> ### *Do not forget the effect of power struggles*
> ### *(which are often hidden from public observation)*
> ### *on the behavior of people who have disabilities.*

One final note, it is important for staff to remember that when we make it about "them vs. us" it is no longer about helping them – it becomes about us and our feelings.   Behavior supports are not about "winning".   Staff must learn to depersonalize all behavior. It is not about them.

Finally, the argument has been made for years that we "needed" to exert our power to deny people things they want or to force them to do something they are trying to avoid. The argument goes that if we "give in to them" then we will be reinforcing "bad behavior". This argument, is even used when it causes crises.

This must stop!

The first premise must be that we do whatever we can to prevent crises. We have much more to worry about by creating more power struggles than we could ever have to fear by reinforcing bad behavior.

Take the fight out of the equation and there is no need for a fight.

> ### *What can be more important to a person than:*
>
> ### *To have people really care about you –*
> ### *about what you think and feel?*
>
> ### *To have someone genuinely care gently for you -*
> ### *even when you are not doing well?*
>
> ### *To have friends?*
>
> ### *To be able to learn without ever being afraid of making*
> ### *mistakes (errorless learning)?*
>
> ### *To know that you are a positive element in this world?*
>
> ### *To know that your choices are respected?*
>
> ### *Think Gently. Behave Gently. Be Gentle.*

Our Teaching Ability

To support others in learning the skill of self-determination, it may be helpful to realize that we are sometimes in the role of teacher. Just remember that an academic teaching background is not necessary for a person to be a good teacher of self-determination skills. Instead, commitment to the task may lead to a catalytic reaction between teacher and student, resulting in productive learning.

Knowing People's Skills and Talents

When people are allowed to use their skills and talents they can begin being a valued member of the community. Staff supporting people with disabilities on their journey towards self-determination need to know how to identify the valued roles, gifts, talents, and contributions of those people. Staff should know how to develop connections and supports based on the things people are good at and the positive roles they can have in their communities.

Opportunities for Quality of Life

Self-determination means that the person assesses for **themselves** whether or not they enjoy a high quality of life, and success in their role in society. We cannot and should not determine quality of life for the person based on our ideas of quality of life. Quality of life encompasses four major areas:

(1) Community Membership,
(2) Self-determination,
(3) Rights, and
(4) Meeting Basic Needs.

For years, the focus has been meeting goals related to safety, individual rights, and training. Now, our focus must broaden to include assisting people with disabilities to enjoy life, rather than just assuring there is an absence of adversity.

Creating a Positive Environment

In order for people to have control of their lives (to become self-determined) they must have a positive environment in which to learn and practice these skills. Many things are influenced by the environment: behavior, decision-making and happiness. When the person perceives the environment as positive, it will promote positive behavior, decision making and satisfaction. Many factors can help make an environment a positive one, in which people can live and learn. Healthy organizations that support people can greatly influence this.

Functional Assessment/Information Gathering

The foundation of Self-Determination-is getting to know the person. . This is accomplished through spending time with the individual, speaking with

those who know and care about the person and formal information gathering techniques.

In order to support the development of self-determination, or the skill of self-governing, in individuals with developmental disabilities, it is necessary to know the person. Knowing the person includes (but is certainly not limited to) learning about the person's skills, abilities, wants, needs, likes, dislikes, routines, preferences, essentials, and learning styles. Information gathering of this type may also lead to a better understanding of the person's behavior, or "why they do what they do." This information gathering is even more important when we are supporting a person who does not communicate in traditional ways. Virtually all activities (or behaviors) engaged in by people serve a purpose, even if the purpose is not immediately evident. Working to understand the purpose of behavior, particularly with persons who have challenging behaviors will enable us to better support the person. If we understand what the person needs and likes, what they dislike and fear, we can support them to build a life which is satisfying instead of frustrating or fearful.

Person-Centered Planning

The concept of person-centered planning has had a significant impact on the field of developmental disabilities. It represents a shift from a "system-centered" approach to a person-centered approach in the way supports and services are provided. It means we truly look not only at each individual's basic needs, but also at their unique preferences and desires. Not that every single desire will be fulfilled, but so that the person can structure their life, to the maximum extent feasible, around their own choices and preferences.

Three concepts to keep in mind when doing person-centered planning.

- Autonomy: people acting according to their own priorities.
- Self-actualization: people exploring and developing their unique talents and gifts.
- Self-regulation: people learning to manage their behavior.

Self-determination develops attitudes and abilities that enable us to take charge of our lives, to make choices, to establish goals based on our needs, interests, and values. We all possess the drive to be self-determined. We need the opportunities and skills to act on it, and thereby increase our quality of life.

The practice of person-centered work is a value, a philosophy, and a process that focuses on the capacities and strengths of an individual, in order to create a vision for a desirable future. This includes an emphasis on each person's gifts, interests, talents and skills, not deficits. It is a process in which the person teaches us about whom and what is important to them and how they want to live. It must be emphasized here that a crucial part of supporting a person to be successful is to understand how that person communicates. The people who know and care about the person share in this exploration, which includes

figuring out what needs to be done to support the person to reach their personal goals. It is about respect, listening, commitment and teamwork. It is a continuous process that enables lifelong growth and development. The process is much more than a written plan. It is a new way of thinking!

Action Planning and Implementation

Action planning and implementation are the parts of person-centered planning which bring the outcomes to fruition. The team must remain committed to carrying out the plan. **Plans that are not implemented are a betrayal of the person's trust, and their family's trust.** Lack of action contributes to cynicism and distrust of the planning process. Committing to action increases the probability that the person will not "wait for years" to achieve their outcomes.

Developing person-centered plans is a means, not an end. Plan documents are merely tools to help people to get the lives that they want. Any plan that focuses on outcomes, demands accountability to the person and is demonstrated through actions. Team members are making a promise **to the person**.

Support Processes

We are beginning to recognize a new standard for evaluating our success in supporting people with disabilities. The objective is more than simply teaching new skills and decreasing undesirable behaviors. Our design of support systems should provide a person with the ability to live successfully in the community and to make responsible personal choices about the kind of life they want to live. Our outcomes should be to assist people who have developmental disabilities to:

- Become full members of their community through their presence and participation in their community,
- Have the freedom to practice their rights,
- Develop and maintain a variety of valued personal relationships,
- Develop and maintain a variety of valued roles,
- Express preferences and make choices in everyday life,
- Have a meaningful life that matters to them and others that care about them,
- Have opportunities to hold respected roles and to live with dignity, and
- Continue to develop personal competencies.

These outcomes are in harmony with the Missouri Quality Outcomes.

Building a Foundation

The major step in working with people who have developmental disabilities is to determine how the person wants to live their everyday life, to compare that with how they are living at present, and to develop and implement a plan to make the needed changes in order to fully participate in the mainstream of community life.

How can we assure people have control of daily routines? Ironically, it is often not the big decisions in our lives that make the largest difference in whether we are happy on a day-to-day basis. Sometimes, the things that can cause us the most frustration during our everyday lives are things like: not getting our morning cup of coffee; having to take our shower in the evening instead of the morning; working with people who never smile or seem happy to see us; having to wait for others when we are ready to go; being around noisy people all the time when we like to be quiet, and the list goes on.

People who have disabilities often live in places they did not choose, with people they did not choose to live with. They often work at jobs they don't like and that pay sub-minimum wage. Typically their lives are lived in largely non-inclusive settings.

When we do not have control over some of these seemingly small parts of our lives, we usually communicate our unhappiness in some way. Sometimes we get irritable, or depressed, or angry.

> *People who have developmental disabilities communicate their unhappiness through their behavior, just as everyone else does.*

Much of the time people who have disabilities live in situations where everything is decided for them, so they have days filled with many little frustrations. The daily routines are established by staff and take little account of individual differences and preferences. Effective behavioral support requires that we recognize and respect people's unique routines and preferences to the greatest extent possible. In our new way of thinking, this becomes our major priority instead of something we "might do if we feel like it". It probably will take a bit of extra thought and effort to accommodate these differences, but it can result in big payoffs for the individual and for the staff.

> *It is our <u>obligation</u> to assist persons with disabilities to have the <u>maximum</u> amount of control over their daily routines, within <u>the same</u> responsible limits <u>that all other adults have.</u>*

By responsible limits, we mean that we are obligated to protect persons from harming themselves, or others, to the extent that is possible and reasonable. Such issues as disputes over program rules, disputes between individuals, and

objections by individuals to program goals should be addressed by a serious and legitimate process of arbitration which gives the individual's viewpoint primacy in all decisions about the person. After all – it is their life and not ours.

An example might be helpful here in understanding the significance of our daily routines.

Marge lives in a group home with five other women. When Marge gets home from the sheltered workshop at 3:30, she asks the staff if she can take a shower. Staff tells her, "No, it's not your time."

A little later Marge again lets the staff know she wants to take a shower. They tell her, "No, you'll take it before bed when it's your turn." Marge sulks in the back of the house for several hours. The other women she lives with get frustrated with her as she won't do anything with them because she's "mad". Staff is angry with her because she's sulking. During this three hour time period there was always at least one bathroom free. Marge didn't need help taking her shower.

Based on this incident and others just like it, staff are thinking about writing an objective in her plan to interact more with others and to be more sociable. From Marge's point of view, she may not feel comfortable doing that until she's clean and relaxed. If we listen to what she is telling us about her routines, not only will Marge's life be more comfortable for her, but the others she lives with may be able to enjoy being with her more.

How do we support people to build a future? None of us live in isolation. The people we know and the things we do give our lives meaning. We have friends we can talk to about both the good things and the bad. We have roots that tie us to other people and places. We belong to various groups and organizations that let us share beliefs, use our talents, and give to our communities. There are people who would help us out in a crisis. In short, we **belong**. Many people with disabilities have lost these ties to the broader community and only know people who are involved in the service delivery system. Our second step is to support people in building connections to others and to the community and to help build an image of what the future might be like for that person based upon their talents, skills, desires interests, and preferences.

Challenging behaviors often stem from an unsatisfying life. Unfortunately, some people with disabilities are excluded from participation in activities they would enjoy with others in the community because of their behavior. Recognizing the importance of including people in the life of their community, we must support the person in finding those places and activities in the community which they find enjoyable and in which challenging behavior can be overlooked, reduced or replaced with behavior that meets the same needs. We

are learning that if we can support people in building a meaningful life, there will be a decline in challenging behavior.

> ***We need to learn to assist the individual by building on those pursuits which they most enjoy.***

It is in these pursuits which give the individual pleasure, or a sense of pride and accomplishment, that new behavior can best be taught. With new, more appropriate behaviors, the individual can work toward a future of their choosing.

People with developmental disabilities also have the right to their own belongings, space, and control over their daily routines. If a person does not have a good reason to get out of bed in the morning, that lack of purpose will affect their behavior for the rest of the day. They should have the opportunity to select and plan for things they would like to work toward acquiring in the future. These are all things that should be addressed fully in a person-centered plan.

<u>How do we assure person-centered planning?</u> Supporting people in building a lifestyle can be accomplished through the use of person-centered planning processes. Person-centered planning is a term used to describe a variety of life planning techniques. In some ways it resembles individualized habilitation planning, but it incorporates some important improvements on that process. Person-centered planning reflects not only a change in thinking about people with disabilities but also offers new techniques for identifying and pursuing what the person wants and needs. Please see Appendix, page110 for resources regarding different planning techniques.

Consumer Rights

The Division of MRDD has a variety of safe guards in place that ensure that individuals who need behavioral supports are safe and their rights are being upheld. A description of DMRDD policies and procedures are included in Section IV, page 55.

<u>Should We Intervene?</u> Before we do anything designed to change the behavior of another person, we need to think carefully about why we are considering intervention. In the past, many people who have developmental disabilities have lived in situations in which staff have had complete control over their lives. Because we have been accustomed to that situation, it is sometimes easy to forget that just because we may have the power to control someone does not mean we have the *right* to do it. Applying behavioral interventions means we are intruding into that person's life. Before considering intervention we should ask ourselves the following questions:

- Does the behavior present an imminent danger to the person or to others? If the person is doing harm to self or others, or at imminent risk of such, we have an obligation to intervene in some way.
- Is the behavior intolerable or just really annoying? Is it so bad, difficult or painful that it cannot be endured? If the behavior can be tolerated and ignored, intervention may well be unjustified. Here the question needs to be honestly answered, "Why is intervention being considered?" If the behavior is intolerable, we must ask, "Intolerable to whom?" We must strenuously and carefully guard against imposing programs of behavior change for the purpose of staff convenience, social bias, or program rules, especially those that other adults not receiving services would never be expected to abide by.

It is easy to begin a chain of increasingly "bad" behavior because the individual reacts negatively to an intervention that was not justified in the first place. We must be especially careful about this when the behavior is occurring in the person's home. Home, after all, is the place we go to be by "our self."

People who have developmental disabilities have the right to express emotions, including anger. They even have the right to yell or destroy things that belong to them so long as it does not seriously jeopardize their, or someone else's, health or safety. People who have developmental disabilities have the right to object to things they don't like or want to do. Before intervening, ask yourself what consequences would be enacted against **you** if you expressed anger or objections about something you didn't like. Would you allow someone to intervene with you in the same way you are considering? ***If not, then don't do it.***

Is the behavior a barrier to the individual achieving their own personal goals? If we can honestly answer "yes" to this question, we must then balance the intrusiveness or unpleasantness of the proposed intervention with the possible benefit to the individual. It is our responsibility as support providers to assist the individual to learn skills which will allow them to have a life they desire.

In the past, people who have developmental disabilities, especially those with challenging behaviors, were routinely excluded from enjoyable activities, particularly those in which nondisabled persons participate. We now know it is more effective, and more just, to find ways to include these persons in desirable activities in which the disruptive behavior can be overlooked, reduced or replaced with acceptable behavior that meets the same wants and needs. If support staff can help people who have developmental disabilities access meaningful community activities, there is often a decline in undesirable behaviors because of an improved quality of life.

> *Replacement behaviors can best be taught when they are practiced in the desired environment.*
> *This requires planning, problem solving, and commitment on the part of staff.*

Is It The Right Intervention? Behavioral interventions can involve active and pervasive intrusion into another person's life. As such, there is a long history of concern over how to determine the acceptability of a particular intervention for a particular person in a particular situation. How do we know when the level of intrusiveness is too great?

Does the intervention meet the "dignity" standard? No matter what behavioral intervention is being considered, it should be measured against this standard. The dignity standard says that any behavioral intervention must be designed and implemented in a manner that affords dignity and respect for the individual. Even very non-intrusive procedures can fail this test. Considerations should include age, culture and gender.

An example of a strategy that fails this test: staff providing positive reinforcement by saying "Good Girl" to Mary who is thirty years old.

Is the intervention too intrusive for the situation? The level of intrusiveness of an intervention must be balanced by the level of gain/benefit that the person will experience. Obviously, highly intrusive interventions should not be used to address relatively minor problems.

An intervention (which may include an array of procedures) should be the most positive and least intrusive option that is expected to be effective. This

determination must be based upon data and not just staff "feelings". An important element of this standard is that the intervention must be expected to produce a clinically significant effect within a reasonable time period, without violating other standards and while promoting positive behaviors. Obviously the more positive and less intrusive strategies are preferred.

Further ethical considerations: We must ask ourselves at what point a behavior intervention becomes an infringement of an individual's statutory and constitutional rights. If an activity affects a person in a way that would deprive that person of liberty, property, or the pursuit of happiness, then at the least we may be violating an ethical/fairness principle, if not the law.

We also know many things about traditional "behavior management" and why those approaches often fail.

It is incumbent upon us to use the best information
and best practices we have available.

For example, we know that there is a phenomenon known as "recovery from punishment". Recovery from punishment means that once punishment is discontinued the behavior may return to pre-punished levels or higher.

To the fullest extent possible, people who have developmental disabilities should be informed, in terms they will understand, about any treatments or behavioral procedures we are planning to implement. This discussion should include what benefits and risks (if any) are involved, along with alternatives to the suggested plan. The person should be told why we are contemplating the procedure; i.e., if the person has committed some "offense" they should be told what it was. They, and their guardians, must be allowed to object. If they do object, they must not be subject to undue pressure, including but not limited to intimidation, insults, or threats, but must rather be given a fair method to have the matter arbitrated.

Furthermore, behavioral support plans and strategies should be subject to the same degree of confidentiality that other aspects of treatment hold. It is important to remember that behavioral information is considered protected health information and is covered by many rules and laws, including HIPAA. Staff and others who need to be informed should be informed, but it should stop there.

Finally, as a warning, it is critical that data of any type is accurate and complete in order to design effective behavioral supports and strategies.

Unauthorized Techniques

Interventions / restraints that <u>will not</u> be authorized by DMRDD include:

- Seclusion - Placement of a person alone in a locked room or area which he or she cannot leave at will; or any other procedure that prevents egress from an environment.
- Denial of Basic Needs - Withholding of a nutritionally adequate diet or fluids. (Should the individual not eat during their normal meal time, provisions must be made to ensure that food is offered at a later time); denial of sleep, bedding, access to bathroom facilities. This prohibition does not pertain to prescribed medical treatment (e.g., fasting before medical procedures.)
- Medication used as punishment, for staff convenience, or as a substitute for programs.
- Restraints, Time Out, or any other procedure used a punishment, for staff convenience, or as a substitute for programs.
- Behavioral techniques administered by other persons who are being supported by the agency.
- Corporal punishment - Applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique.
- Overcorrection - Forcing the performance of repetitive behavior.
- Placing persons in totally enclosed cribs or barred enclosures other than cribs; limiting a person's mobility by removing crutches, glasses, or disabling a wheelchair.
- Physical restraint techniques that interfere with breathing; prone restraints; restraints which involve staff lying/sitting on top of a person; restraints that use the hyperextension of joints or any technique which has not been approved by the Division, and for which the staff person has not received Division-approved training.
- Aversive Conditioning - subjection of a person to physical pain or discomfort, extreme sensory stimulation (such as electric shock, bright lights or sound), delivery of physically noxious substances (such as lemon juice or Tabasco sauce), humiliating or derogatory treatment (such as putting a bucket over a person's head, spraying water in the face, or name-calling), or situations designed to be mentally or physically stressful.
- Any treatment, procedure, technique or process prohibited elsewhere by federal or state statute, rule or
- Department Operating Regulation, including physical, sexual and verbal abuse, and neglect.

Section II. Positive Behavioral Support Process

Overview

Based on the national definition (*Research and Training Center on Positive Behavior Support*), PBS is a process for designing individualized behavioral interventions based on understanding the relationship between the person's "behavior" and aspects of the person's environment. Positive behavior support is an approach that blends values about the rights of people with disabilities with a practical science about how learning and behavior change occur. The overriding goal of PBS is to enhance quality of life for individuals and their support providers in home, school, and community settings.

The behavioral support process is based on:

- The belief that anything the person is doing consistently (even problem behaviors) is serving some desired purpose for them as they attempt to achieve a valued outcome. We need to determine the function(s) that this behavior is serving for the person.
- The behavior may help the person get something they want or avoid something they don't want.

We are beginning to recognize a new standard for evaluating our success as a support system to people with disabilities. The objective is more than simply teaching new skills and decreasing undesirable behaviors. Our design of support systems should provide a person with the ability to live successfully in the community and to make responsible personal choices about the kind of life they want to live. Outcomes of PBS should be to assist people to:
- Belong to their community.
- Have control of their daily lives.
- Have a variety of personal relationships.
- Have the opportunity to advocate for themselves, for others, and for causes they believe in.
- Have valued roles in their family and in their community.
- Have plans that reflect how they want to live their lives, the supports they want, and how they want them provided.
- Be connected with their past.
- Live and die with dignity.
- Have their communication understood and receive a response.
- Feel safe and experience emotional well being.
- Have behavioral supports provided in positive ways.
- Be supported to attain physical wellness.
- Be provided support in a manner that creates a positive image.
- Be actively supported throughout the process of making major lifestyle changes.

- Express their own personal identity.
- Be supported in managing their home.
  (From - Missouri Quality Outcomes)

The remainder of this chapter will set forth a process which relies on a series of "building blocks" to assist the person in achieving these stated outcomes. This process rests on a foundation of supporting the person in building a lifestyle that respects their unique "routines" of daily living while building a desired future. An essential component of the foundation is the continual work of enhancing and respecting communication with the individual. This foundation will apply to all people who have developmental disabilities.

PBS has four main components:

1) Functional (behavioral) assessment (an information gathering process)
2) Comprehensive intervention (proactive / preventative strategies, intensive strategies, crisis intervention)
3) Lifestyle enhancement (person-centered thinking and planning process)
4) Team approach (collaborative team work, supporters promotes the process, etc.)

Functional Assessment / Information Gathering / Communication

Positive behavior support is a *dynamic problem solving* team process. Information gathering begins the problem solving process and includes a variety of formal and informal tools necessary to gain a greater understanding of the person. Information is gathered as a collaborative process, from multiple perspectives, across a variety of settings and situations.

The purpose of the functional assessment is to determine the cause of the behavior and how we can assist the individual to exchange the undesirable behavior for a more effective and acceptable behavior. We cannot forget the person when we evaluate either the person's abilities or the person's needs.

Comprehensive functional assessment is based upon three value-based assumptions. Behavioral support must:

- ensure the rights and dignity of the person,
- attempt to understand the behavior and its relationship to things that are important to the person in order to teach effective alternatives, rather than simply attempting to eliminate the undesirable behavior, and
- look at relationships between person's behavior and all of the elements of the environment (including other people) rather than looking solely at the person.

Functional assessment analyzes the relationship between events in a person's environment and the occurrence of challenging behaviors. Through functional assessment we identify the consistent patterns of behavior that support hypotheses (tentative conclusions) regarding causes of challenging behavior(s) and/or predictions regarding when and where those behaviors will occur.

Ruling out other problems - the initial screening

Sometimes problem behavior results from medical or psychiatric conditions, or a medication side effect. Using a behavioral intervention alone in these situations is often ineffective or even harmful. It should be noted that behavioral strategies can be helpful <u>in conjunction with</u> medical or psychiatric interventions for those people who need this level of psychiatric/medical care. It is critical that **all** options are explored to find the most effective intervention(s) in each situation. We need to make sure these conditions are considered when we make decisions about the right action to take concerning a problem behavior.

Medical and psychiatric conditions should always be considered, but particularly so when the behavior changes suddenly or is atypical for the person.

While the treatment for these conditions may be in the hands of other professionals, it is our obligation as support personnel to ask the right questions and be persistent in our demands for answers. Many medical conditions are invisible and many individuals have only their behavior to communicate when they are in pain or don't feel well.

Medical Conditions

Do you know what kinds of ailments the individual is predisposed toward? Does the person have a history of ear infections, indigestion, headaches, allergies, sinus problems, urinary infections, backaches, arthritis, etc? Any of these, and hundreds of others, could be causing pain. It could be something even more serious, such as an impending heart attack. It is particularly important for support staff to be alert to possible medical problems when the individual is unable to clearly communicate what is going on.

People who have developmental disabilities must get prompt medical attention when they need it. They also have the right to stay home sick and be pampered as you and I do.

> ***People who have developmental disabilities are more likely than the general population to have physical illnesses, medical complications and syndrome related problems***

Medication Side Effects

Side effects from medication can result in changes in behavior that are unrelated to the purpose of the medication. This is especially true when various medications are used in combination. It is our obligation as support personnel to be assertive in understanding the effects of medications on the persons we support. Sometimes we are the only ones in a position to observe negative or even dangerous drug effects. We may not be medical doctors, but we can ASK THE DOCTOR, and we can REPORT CONCERNS TO THE DOCTOR. **Failure to ask and report can be interpreted as neglect.** Pharmacists can also be helpful in answering questions about drug interactions and drug side effects. There are published reference books available at book stores and some reputable web sites (like www.drugs.com) which list medications and their side effects. It is a good idea for support personnel to have such a reference available and to consult it as needed.

Psychiatric Conditions

People who have developmental disabilities can have psychiatric illnesses or emotional problems just like everyone else. These can range from temporary situational upsets (like being depressed over the death of a pet or fear of an upcoming hospital stay) to major mental illnesses like schizophrenia. If there is

any question at all, the individual should be seen by a specialist, such as a psychologist or a psychiatrist. Some of us may have seen psychiatric approaches in the past misused with people who have developmental disabilities, including the inappropriate administration of medication to control behavior. This is considered a primary responsibility of people who are responsible for assuring reasonable health and safety of people who have disabilities, especially in light of the laws and rules related to chemical restraint. However, we must also recognize the rights of persons with disabilities to benefit from medications and therapies that are properly used, and which can help relieve medical and psychiatric conditions, just as insulin is used to help people who have diabetes.

Other Life Stressors

Has the individual experienced a significant life change? Have they lost a roommate or co-worker? Have they experienced inconsistency of staff support? Has a family member moved or died? Is there an impending event which is causing stress (positive or negative)? Any of these events (and others) could have meaning for the individual far beyond what we may have suspected. Check it out. If possible, maybe a change needs to be changed back. If not, perhaps we just need to respect the emotion that is being felt and help the person deal with it. Examples of tools which can be used to assess the individual's situation are included in the Appendix, starting on page 87.

As stressful as our lives are, the lives of people we support are often much more stressful, for a variety of reasons. Think about how stressful and frustrating it is when people have little or no control over their own lives. As support personnel we should constantly remind ourselves that a decision which we might consider making as a practical business matter (such as switching roommates from one group home to another one across town) may result in months of grief and confusion for the persons involved.

The reality is that stress has real physical and psychological effects on us. It can affect how we think, feel, and behave. It can make existing problems seem worse – or actually make them worse. It is not a far reach from unabated stress to an anxiety disorder.

How many of the following behaviors, associated with a progressive increase in stress and/or anxiety levels have we seen in people who have disabilities?

Avoidance & Withdrawal
Physiological Arousal
Physiological Illness
Over Activity
Irritability
Anger, Rage
Disorganization of Thoughts

Stereotypic Behaviors
Self-Stimulation
Self Injury
Fantasies
Delusions & Hallucinations

The simple point here is that rather than assume that people are intentionally behaving in a certain way, let's consider that perhaps they are dealing with serious stress/anxiety and what they need more than anything is a break or some reassurance, offers of assistance, encouragement, etc. The last thing we usually need in a time of extreme stress is more stress – especially increased expectations or demands from others.

Unfortunately, when people are experiencing a lot of stress they are more likely to have a behavioral crisis. The patterns of behavior that precede these crises tend to be "contagious". This means that staff tends to get a bit anxious too. Both because they can't figure out how to control the behavior (or the person) and they anticipate the potential for a crisis. It is critical for staff to be able to remain calm so that they can model the correct behavior for the person to imitate and so that they can provide the support that the individual needs.

Gathering Information:

If we have developed and implemented a good person-centered plan, actively worked to maximize the individual's ability to communicate with others, maximized our use of preventive strategies, implemented early intervention strategies, and done an initial screening for medical, psychiatric or pharmacological causes, we will find we have successfully provided behavioral support for most of the people we work with.

Yet, for some people, this will not be enough. We will need to pursue the more time consuming and technically demanding process of using intensive support strategies. It is possible that consultation with a specialist in positive behavioral support strategies would be of benefit at this point.

Some people have learned very complex combinations of behaviors as a means of dealing with various situations. Sometimes this set of behaviors can be used to accomplish more than one kind of result for the person. It can be very difficult, if not impossible, to untangle this web of interactions merely by watching the person.

Yet, making sense of what is going on is critical to being able to intervene to support the person in learning more effective ways to interact. ***When using intensive support strategies, the goal is to understand the nature of the problem behaviors before intervening.***

Intensive support involves the use of multiple strategies, since behavior is complex and is rarely attributable to one cause. This process places great emphasis on determining the function of the problem behavior in order to design and deliver effective and comprehensive behavioral support. The steps in this intensive support process are:

1. Conduct a comprehensive functional assessment (to include environmental assessment which includes staff interactions);
2. Develop hypothesis statements which attempt to explain the behavior;
3. Design and implement advanced support strategies;
4. Evaluate the effectiveness of the supports;
5. Revise, as necessary.

The purpose of intensive support strategies is to figure out what is going on so we can most effectively teach the person ways to meet their own personal wants, needs, and goals.

Rule out other issues such medical, pharmacological or psychiatric conditions. Describe the individual's general health and well being. Here we again consider medical, pharmacological and psychological issues. Many researchers believe that a large majority of people who have a behavioral crisis have an undiagnosed and/or untreated physical health problem: (think how difficult is it to get people to have appropriate dental care or to get a woman to an ob-gyn appointment, or to get good medical care for other "hidden" problems, like an inflamed prostate). One simple assessment of behavioral/mental health for people who have a cognitive disability is included in the Appendix, page 87.

Identify and define the problem (targeted) behavior in observable and descriptive terms:

- Determine the impact (social significance) on the individual in the numerous environments and contexts in which they operate.

- Draw tentative conclusions to guide more specific assessments about events that are regularly associated with the problem behavior. This might include information about the persons "targeted behavior" including:
    - Topography = how is the behavior preformed.
    - Frequency = how often the behavior occurs, per day, per week, per month?
    - Duration = How long does the behavior last when it occurs?

- Intensity = What is the magnitude of the behaviors, does it cause harm? (i.e. self injurious behavior - low intensity- no injury, medium intensity= leaves a red mark on skin, high intensity = injury requiring treatment)
- When the problem behavior is likely or not likely to occur, and
- What events typically happen before or after the problem behavior occurs.

Describe the person's quality of life emphasizing what is most important to and for the person.

- Identify the individual's strengths, interests, preferences, and skills. These may be used to teach or enhance desired alternative behaviors.
- Describe the relationships between the person's life experiences and the problem behaviors. Include participation in varied and meaningful activities, opportunities for choice and control, relationships, and inclusion in community activities.
- Describe the person's ability to get things they want and need (things that are important "to" them).

Overall, specific information gathering leads to:

- Identifying specific variables that may be contributing to the problem behavior; e.g., skill deficits, physical condition.
- Identifying specific settings, situations activities, and people that predict when the problem behaviors are most or least likely to occur, across a full range of typical daily routines.
- Identifying the function or functions (purpose) of the problem behavior; i.e., what is the individual trying to get or to avoid?

Information for the functional assessment process can be gathered through direct and indirect methods. Direct methods include:

- Simple observations (may be documented by family members, staff anecdotal notes, etc.)
- Data collection and systematic direct observation (utilizing formal data collection tools (i.e. ABC data collection and Scatter Plots forms. See Appendix, pages 92-93)

Indirect methods include:

- Formal and informal discussions, surveys, questionnaires, and interviews that include the person who has the developmental disability, Family members, support professionals, friends, physicians, pharmacists, employers, co-workers etc.). Some examples include the Functional Behavior Assessment Interview form. See Appendix, page 90.
- Record reviews (i.e.: historical and current information about what works vs. what does not, past psychological and medical testing results,)

Building a Foundation by Expanding Communication

Effective communication is critical to helping support anyone, but is it even more crucial when supporting a person who has behavioral challenges. It is difficult for most of us to imagine the intense frustration felt by persons who are cut off from communication. Many of the people we work with experience this kind of frustration as a regular part of their lives. Everyone, without exception, has important things to say.

> *Many of the behavior problems we see are lessened or eliminated when we figure out a way to "hear" and respond to what the individual is trying to tell us.*

There are three factors related to communication that bear further discussion here.

<u>Listening</u> involves concentrating patiently and fully on what the person is saying. It also involves understanding all of the ways people communicate besides just with the words they use. This includes things like tone of voice, facial expression, and body language. Sometimes when someone is not doing or saying anything, the silence is communicating something.

Behavior really is a way for the person to communicate something. We may or may not like the way they are choosing to let us know something, but it is a way that has worked for the person in the past, maybe for decades. In that sense it has been an effective means of communication for the person. Our job is to understand what the person is communicating through the behavior and to let them know we understand and to support them in learning more effective ways of communication that are considered more acceptable. An example might help make this clearer.

Vicky lives in an apartment she shares with two friends. Agency staff come every afternoon at 4:00 when Vicky gets home from work and stays until 8:00. At 4:30 staff says to Vicky, "It's time to fix your microwave dinner." Vicky says, "No." Staff says, "Come on Vicky, it's time to fix dinner." Vicky stomps her feet and yells "No". Staff say, "Vicky you've got to learn to do this or you'll never be independent and you won't be able to stay here". Vicky throws a bowl which shatters on the floor and starts screaming. Staff decides she needs a behavior plan to increase compliance with commands.

Was this really about Vicky's being non-compliant? Did we really listen to her? She said, "No". We can take that as simple non-compliance or we can look deeper. Maybe Vicky means, "No, I don't like to eat dinner at 4:30". Maybe Vicky comes from a family that eats dinner at 7:30. Maybe she's not hungry now. In order for us to provide effective support for Vicky we need to listen to what she's telling us with more than just her words. We are in <u>her</u> home, working for <u>her</u>, to provide <u>her</u> with support. Yet when she tells us "No" we threaten to make her leave her own home. From her point of view, this simply feels like coercion and the unfair imposition of power.

Are the staff bad people? No. In fact, they do a very good job with most things. In this case, they are doing what they believe to be their job - running the cooking program and sticking to the schedule. If the role for staff is to learn Vicky's natural routines and to listen to what she's saying through words and behavior, staff will instead do a couple of things. One will be to plan dinner much later in the day -- according to Vicky's schedule --- and the other will be to help Vicky find other ways to tell us more about what she's thinking or feeling.

> ### In order for the alternatives to be effective, we have to listen vigilantly to what the person is telling us.

This brings us to the second factor in good communication, responding.

<u>Responding</u> - It is not enough to figure out what the person is communicating. We have to let the person know we've heard them and respond to their communication in a manner that reflects the same urgency the person is feeling. Returning to the example, if we tell Vicky we'll change the dinner schedule next week, she'll probably still throw the bowl on the floor because Vicky means tonight, right now, she doesn't feel hungry. Another example might be helpful here.

Paul is a middle aged gentleman who lives in a group home with seven other men. Most of them are quite talkative and, in fact, a bit rowdy. Paul, on the other hand, is normally pretty easy going and much quieter

28

than the rest of his housemates. Paul uses a communication board in addition to gesture and facial expressions to let us know what he wants. Staff decides that Paul's board needs to be reprogrammed so he'll be able to "talk" about more things. They take the board to the agency office so they can give it to the speech therapist at the regional office to reprogram. No one has time to do it right now, so Paul's communication board sits at the office.

A month later, staff writes up an incident report on Paul. He threw a book at one of the other men. Over the next few months, there are more incident reports. Paul has begun throwing things at several of the men. Now, Paul has a behavior plan. Staff decides there is really no point in getting the communication board fixed. After all, Paul will probably just throw it.

If we take a step back from the situation, it is obvious that Paul needs his communication board. In that rowdy household, he doesn't have much hope of being heard without it unless he gets the others' attention by throwing things. We failed to understand how important it was to Paul. We failed to listen when he told us through his behavior that a month was much too long to wait.

Of course there may be a few times when the answer really does have to be, "No". But it is usually easier to hear "No" and accept it when you truly believe the person listened to you and when they've explained their decision. Sometimes the answer can be, "No, but we can do something similar instead" – or – Maybe we can do that later." In other words, maybe we can do something which is close to what the person wants.

> ### *The goal should be to say "Yes" with our words and behavior – with our responding – the vast majority of the time.*

All of this really hinges on knowing the person well and coming to understand their communication. This brings us to the third aspect of communication we need to work on with people whom find challenging.

Alternative Communication Methods We need to do everything we can to increase our understanding of the person and to support the person in expanding their communication repertoire. This is critical when working with people who have behavioral challenges. If we don't do this, we will leave the person with no effective way to get what they want other than through behavior. Examples of the kinds of things to consider include the following:

- Words & Sign: Increasing the person's ability to communicate through verbal or sign language or our ability to understand the person's communication through sign language.

- Gestures, Pictures, Symbols: These things may be used to provide an alternative means of communication for someone who does not use words or they may be used to expand the communication of someone who uses some language.

- Communication Boards: Mechanical devices used to expand the person's ability to communicate.

- Personal Dictionary: Providing a description of the person's gestures, expressions, sounds, body language, or other responses. Ask people who know the person well to make a best guess about what each of these things mean (i.e., what the person is communicating). Provide a description of what staff should do in response to the person's specific communication. As new staff begin to work with the person, this Personal Dictionary will be invaluable.

The following is an example of building a means of communication which then directly reduces a behavior that could be dangerous.

Linda doesn't like working at one thing for very long. She needs lots of breaks. She has found one sure way of getting a break when she is ready. She throws her work across the room. Linda doesn't mean for it to hit anybody, she just doesn't want to look at it any more. The problem is, sometimes somebody does get hurt. However, Linda's method has proven effective in getting a break from her work, even if it is only for a moment.

Linda uses very few words, but we think she understands most of what we say to her. We give Linda a special card she can hold in the air that says "Break" in bold letters. The minute we see Linda raise the card, we instantly remove her work for a few minutes. Because we do this right away, it works as well for her as throwing her work did. She no longer has a reason to throw her work because we have a better way to communicate.

> **If we support people in building a lifestyle that respects their routines, helps them pursue their own personal goals, and enhances communication, we believe that most of what we call "acting out" or "behavior problems" will disappear.**

Hypothesis Statements

Information gathered during the functional assessment needs to be summarized and reviewed <u>for the purpose of looking for common patterns and themes</u>. This leads to the formulation of hypothesis statements: a "best guess" explanation of the problem behavior(s).

Developing Specific Hypothesis Statements:

The hypothesis can be a fairly specific statement dealing with antecedents or setting events in that it identifies the events and circumstances associated with the problem behavior. The statement also identifies the function the behavior serves. What does the person gain or avoid by using the behavior in this situation?

> *For example, when people she doesn't know come within arm's length of Paula, she starts screaming and thrashing her arms. When she does this, people move away from her. People getting too close is the antecedent. Screaming and thrashing her arms is the behavior. Getting people to move away is the function the behavior serves for Paula. It gets her space back.*

The same problem behavior may serve different functions in different situations.

> *When Paula is asked to wash the dishes, she starts screaming and thrashing her arms. When she does this, staff takes her to "time out". When Paula screams she doesn't have to do the dishes. The antecedent is being told to do a task she doesn't want to do. The behavior is the same -- screaming and thrashing arms. The function, in this case, is not having to complete the undesirable task.*

The same problem behavior serving one function can also be set off by many different situations.

> *When people put things too close to Paula, she starts screaming and thrashing her arms. People protect their things by moving them away from Paula. Paula gets her personal space back. The antecedent is somewhat different, but the function is the same.*

Developing Quality of Life Hypothesis Statements:

This is an attempt to offer a broad contextual explanation of the problem behavior. This may include things like possible lifestyle or quality of life influences, medical issues, or the individual's overall skill deficits. Global hypothesis statements lead to modifications that could be made for long-term prevention, as well as additional skills that could be targeted for intervention.

For example, we may learn that Dave starts banging his head when he hears loud, shrill noises. He is living on a busy street that the police and emergency vehicles use frequently. We need to support Dave in finding a quieter place to live as soon as his lease is up or as soon as we can help him find someone to sublet his apartment. Because Dave also uses very few words, he is using behaviors to get what he wants in a variety of different kinds of situations. We need to actively support him in developing alternative ways of communicating.

Preventive Strategies

> *Remember: A GOOD PERSON-CENTERED PLAN __IS__ PREVENTION!!*

There are a number of things we can do to prevent behavior problems from developing. We should structure living and learning environments in ways that make positive actions more likely and problematic actions less likely. These fairly simple <u>preventive measures</u> seek to teach alternatives and prevent more significant behavior problems. In doing this, we are supporting people who have disabilities in learning effective ways to reach their own personal goals.

Preventative Strategies should be noted as the "supports" that are identified in the person-centered plan.

Some of these strategies are:

- <u>Help People Get a Life They Want.</u> When people are actively engaged in a life that they like they are less likely to have behavior problems. When they are working toward goals that matter to them, they have less time and reason for behavior problems.
- <u>Identify Positive Behavior.</u> Identify the positive things the person is doing that help them to reach their own personal goals. This can include things like communicating, interacting with others, doing things without someone else suggesting them first, finishing tasks, and following instructions.

> *There are times when we need to re-think the meaning behind "problem behavior". Once others gain a greater understanding of personality and preferences, some perceived "problem behaviors" may be transformed into something positive. For example, "stubbornness" becomes seen as "the ability to resist significant pressure or stand up for what is right" and "argumentative" may become "advocate for his/her position". This gives us an idea of how important it is to take time to understand and to get to know who the person really is and what they are trying to convey to us. It is a matter of "thinking" differently.*

- <u>Identify Rewards</u>. Identify things the person finds rewarding. The purpose of this is not to find out what things to "take away" (punishment) from the person. Many people take this for granted, but it is often critical in the process of working with people we find challenging. Sincere praise is an underused reward. Praise can be communicated in many ways (one person counted over 100 ways) - from a bright smile, to a thumbs-up sign or a high-five.
- <u>Consistently reward positive behavior</u>. When working with people with challenging behavior, it is important to make sure the person is rewarded for positive behavior and that includes positive attempts.

33

We must reward effort and not just success or the effort will be very short lived. The frequency of rewards, recognition, and encouragement needs to be high.

> **The rule used in some of the most successful programs is 10 positive interactions (rewards, recognition, encouragement) for every 1 corrective/directive interaction.**

Remember, however, that we must be working toward the day when the person can be rewarded more naturally for their positive behaviors.

> *For example, if Ralph finds a pat on the back rewarding, and if we believe completing tasks more frequently will help him get the job he wants, then we should immediately give Ralph a pat on the back every time, or almost every time, he completes a task. We could also shorten the length of each individual task so that he has a higher number of tasks that he completes – thus, getting more pats on the back. We also can praise or encourage him before the task is complete.*
>
> *As time goes by, the pats can be reduced to an occasional smile. Ralph's true rewards will be as he becomes an obviously more liked and trusted worker, or whatever life goals he is striving for.*

Don't "reward" ineffective or problematic behavior with attention (even correction) unless **absolutely** necessary. Experience suggests that some people find attention rewarding, even negative attention. Further, how would you feel if every time you made a mistake someone had to make a point of bringing it up?

> *If I yell at Ralph when he doesn't finish a task, he may see it as positive. At least someone's paying attention to him. The result may be that Ralph finishes even fewer things because I'm paying more attention to him when he doesn't. The obvious solution is to be sure to pay attention to Ralph when he completes a task by giving him the pat on the back he likes and to be sure "not" to give him attention when he doesn't finish.*

At the same time, however, not all undesirable behavior can be ignored. If Ralph starts banging his head hard against the door, I know he could seriously injure himself and I need to stop the behavior -- even though I'm also giving him attention by the mere act of doing so.

There is a balance here that needs to be carefully maintained. Some things cannot be ignored. On the other hand, some things can be improved by ignoring them.

BE VERY CAREFUL THAT YOU ARE IGNORING THE INAPPROPRIATE BEHAVIOR BUT NOT IGNORING THE PERSON! IGNORING THE PERSON ALMOST ALWAYS MAKES THE PROBLEM BEHAVIOR WORSE.

- <u>Structure the Environment</u>. Structure the person's home and job or day program to the person's advantage. Sometimes our surroundings increase or decrease the likelihood that we will respond positively. Set the environment up in such a way that the person is more likely to experience good outcomes.

   For example, we know that Ralph is very sensitive to loud noises. We believe he quits working and starts banging his head more often when there is loud music on the radio. We also know that he works better when he has his favorite, padded chair to sit in. By making sure the radio station is changed, the volume is turned down and Ralph has his chair, we increase the likelihood that Ralph will finish more tasks which will help him reach his goal of getting a job.

The preventive strategies described above are intended to support the person in learning positive, constructive ways of doing things to help them reach their own goals.

Remember that the more control the person feels over their own life, the less likely they are to be experiencing anger, frustration or depression -- emotions which may often be communicated with behavior. Preventive strategies set up opportunities to engage in positive behaviors and deliver many rewards for those positive behaviors. Providing negative feedback for undesired behaviors is not considered to be a preventive strategy. It is considered a response or reaction to undesirable behavior and will be discussed later.

Remember: A GOOD PERSON-CENTERED PLAN <u>IS</u> PREVENTION!!

35

Intensive Support Strategies

Remembering that we are dealing with complex combinations of behavior occurring in complex situations makes it easier to understand the necessity of multiple intervention strategies which address various facets of the problem. Intensive support requires the use of strategies from all of the following categories.

Antecedent/Setting Events Strategies: These interventions change the circumstances that cause the behavior to occur or change the environment so that the desired behaviors are more likely to occur. Antecedent interventions can be very powerful short term solutions, resulting in immediate reductions in problem behaviors. Some examples include: altering seating arrangements, providing rest periods, changing tone of voice, providing preferred activities and increasing choices.

Alternative Skill Training: Alternative skill training gives the person the opportunity to learn skills which give them more control in more appropriate ways. It is much more effective when the skills are taught where and when the skill will be used. These types of skills are very effective in the long-term but the effects on reducing the problem behaviors may not be immediate. Learning alternatives takes time, especially for long-standing problem behaviors. There are three approaches to Alternative Skill Training.

- **Functional Equivalence Training:** The person learns an alternative skill that will serve the exact same function as the problem behavior but with increased effectiveness and social acceptance.
- **General Skill Training:** The person learns alternative skills that alter the contextual influences for the problem behavior; e.g., learning a form of communication so that needs can be expressed appropriately, assertiveness skills training, problem solving skills, etc.
- **Self-Regulation Training:** The person learns coping skills for difficult situations; e.g., anger control, relaxation.

See the "Alternative Skills to be Taught" in the Appendix, page 106.

Consequence Strategies

"Consequences" is often translated as the unofficial "code word" for punishment. It is important to recognize that consequence strategies are not just about negative things that happen following behavior. Consequences serve three primary functions:

- **Strengthen alternative or desired behaviors** This is accomplished by immediately and consistently reinforcing the person when they use alternative, more desirable skills.
- **Weaken the effectiveness of the problem behavior** This is accomplished by teaching the person that the problem behavior is no longer effective in producing their desired outcomes. These behavior reduction strategies may include planned ignoring of inappropriate behaviors (remember - without ignoring the person), redirection, limit setting, etc., but must always ensure that:
  - ◊ negative consequences must appropriately address the function of the behavior,
  - ◊ the least intrusive, but most positive, humane, and effective strategy is employed, and,
  - ◊ negative consequences are acceptable for <u>all</u> same aged people.

Many of the interventions in this category need to be used very carefully. Interventions such as time out, response-cost methods, over-correction and restitution can easily infringe on the person's human or legal rights. They are referred to as "decelerative strategies" because they are intended to reduce (decelerate) the use of problem behaviors by making them less effective. The problem behaviors become less effective because they are now linked to negative outcomes.

These techniques should only be used if it can be documented that after sincere, good faith efforts that other methods
are not producing positive effects for the person. They must be reviewed and approved by DMRDD staff.

Long Term Prevention Strategies: These intervention strategies address broad quality of life factors in an effort to build long-term supports for new alternative behaviors. Just as any behavior strategy should be in concert with the person-centered plan (PCP) these interventions must be incorporated into the PCP.

Three goals of long term strategies are to:
- Make permanent or long term adaptations that will help to maintain desired alternatives. This may include teaching self-monitoring, shared problem solving, ongoing feedback, etc.
- Improve lifestyle factors related to overall quality of life. This includes opportunity for engagement in meaningful activities, participation in varied community activities, more choice and control, personal relationships with others, etc.
- Facilitate inclusion. This must be viewed as an integral part of the program from the onset. A program designed for a segregated setting will likely fail in an inclusive environment making transition later impossible.

Emergency Strategies

> **Our goal must be to eliminate the use of restraint by doing whatever we can to prevent it from being necessary.**

When an individual is at imminent risk of physically harming themselves or others, that situation is considered an emergency. **Emergency situations are not "teaching moments."** They require immediate intervention to protect persons engaging in severe sensory, aggressive, and/or destructive behaviors from doing serious damage to themselves or other people. **Emergency situations *are not* behavioral support interventions.**

> **Imminent (adjective): expected to happen in the immediate future**

The goal of emergency procedures is very modest, namely, to end the emergency situation as soon as possible. The purpose is not to figure out the meaning of the behavior, nor to teach an alternative behavior. **It is certainly not to punish or "consequence" behavior.** Rather, it is to interrupt or control an otherwise dangerous or unmanageable situation. Unfortunately, many support persons find these procedures so helpful and are so relieved when the emergency is over that they forget to develop an intervention. This can be considered a form of both neglect and abuse.

Experience suggests that emergency procedures are generally adequate for the *immediate and temporary* control of a problem behavior. They resolve the immediate situations, allowing us then to undertake the more beneficial task of developing behavioral support approaches like those we have discussed in previous sections. Emergencies can and should be dealt with on a case by case basis. Four categories of procedures are useful in resolving emergency situations. *These categories are not intended to be used in a hierarchical approach but rather on an individualized basis.*

Introduce cues (Discriminative stimuli) - Introduce cues that evoke non-problem behavior.

> *For example, even while Samantha was biting her hand and attempting to punch others, it was often possible for her dad to interrupt the crisis by asking her a question such as, "What do you want?" Through use, this question became a powerful cue for Samantha to stop her problem behavior. She would often respond to the question by asking for a break from doing a task, for some music, or for a sandwich. This procedure only worked after some communication training.*

Protect - Protect the individual and others from the physical consequences of the problem behavior.

For example, when Tony slapped or kicked a group home staff person, the staff person would use his or her hands to block/deflect Toni's blows. Likewise, if Jonathan threw a chair or radio at a staff person, that staff person would use a chair or some other large object to deflect the oncoming flying object.

<u>Remove</u> - Remove anyone who is in danger from the behavior problem from the vicinity where the emergency is occurring.

<u>Protectively Restrain</u> - Momentarily restrain the individual during episodes of problem behavior.

> ***Restraint is never justified unless the individual is at imminent risk of harming someone (including themselves). Restraint is an emergency protection method that may sometimes be necessary to protect the person or others from harm. If restraint is used on more than one occasion, its use must be reviewed and approved by the DMRDD staff.***

While we all may know that there can be distinct negative psychological and behavioral consequences for a person who has been abused, what many don't know is that way too many of the people who have developmental disabilities have been abused. For example, several researchers have published data that over 80% of all people who have disabilities have been sexually abused. Some clinicians are reporting dramatic increases in the incidence of diagnosed Post-Traumatic Stress Disorder (PTSD) among people who have developmental disabilities.

> **While we can be appalled by this information, it is far more important that:**
> 1. **We do not minimize the psychological, behavioral, and yes, physical pain that people who have disabilities experience as a result of the abuse they have suffered.**
> 2. **We do not blame the victim of the abuse for their current behavior but instead figure out how to get them the treatment and support they need to be able to fully recover from the abuse.**
> 3. **We do not "excuse" behavior that is causing them more problems or perpetuating a pattern of victimization.**
> 4. **We design and provide supports that bring comfort for the pain to make the problematic behaviors unnecessary.**

More information about the behavior patterns associated with assault is included in the Appendix, pages 108-109.

Restraints

Physical Restraint

This refers to any type of holding of one person by another that prevents that person from moving freely. It does not include mechanical devices. Physical restraint can be as mild as holding a person's hands in their lap to the extreme of using one person or team control techniques. The degree of restraint (i.e., holding an arm vs. a full body restraint) should not exceed the degree of risk. The use of restraints must comply with DOR 4.145.

Emergency procedures are used only when a person's problem behavior escalates to the point where it is endangering the person and/or other people. Staff must be prepared to intervene quickly and safely.   These are not strategies to be used to change behavior.

> *Note that property destruction, by itself, is not an emergency. You must carefully evaluate several factors, including the type of property, who owns the property, the risk of harm, and the legal issues (a broken storefront window carries more risk of legal ramifications than a broken window at the person's home).*

> **Our goal must be to eliminate the use of restraint by doing whatever we can to prevent it from being necessary.**

Provision for the use of restraint in personal plans

For most people, behavior patterns are well established. This means that support teams must determine why problem behavior is occurring, what triggers it, and predict when and where it is likely to occur. Teams must then design and implement strategies to teach better methods for people to achieve their personal goals more effectively. Some persons' personal plans will also need to include the methods to use when their behavior escalates to being out of control, particularly before new skills and replacement behaviors are learned. These methods may include ways to physically hold someone to prevent injury.

All persons supported by the Division who have a current history of exhibiting behavior that is considered dangerous to their selves or others must have a personal plan that includes individualized procedures for support staff to use in those situations. The procedures must include:

- What to do to avoid the emergency,
- Steps to de-escalate the person's behavior, and
- Specific techniques to use if the person is endangering himself, others, or property to the extent that physical restraint is needed.

These procedures and techniques should be specific to the individual, developed and designed as a result of a functional assessment of that person's behavior. Personal plans with emergency procedures must also include positive strategies that specifically define the support needs of the person. Staff who implements these plans must be trained on all parts of the plan, including the *specific* physical restraint techniques to use with that individual if necessary.

On occasion, staff will have to intervene with someone who does not have a personal plan that specifies how to physically intervene in an emergency. This may be a person who is new to the system, who is not yet well known, whose functional assessment is not yet completed, or someone who has not displayed this behavior before. Regardless, staff must intervene to protect from harm if necessary. Teams should work closely together during times of transition to ensure support needs are being met and are closely described in the personal plan.

Supporters should use only restraint techniques they have been certified to perform through participating in a nationally recognized training program approved by the Division of Mental Retardation and Developmental Disabilities as stated below.

> Currently, the two national programs recognized by the Division are those sponsored by the National Crisis Prevention Institute (CPI) and The Mandt System. Persons who provide behavioral supports that may include physical restraint must be certified through one of those training programs before they can intervene physically with anyone.

If it becomes necessary to physically restrain a person who does not already have a personal plan that includes specific individualized emergency procedures, the team must convene and develop such procedures to be included in the personal plan as soon as possible after the first instance of the use of restraint.

Documentation and review of incidents

All situations that require physical restraint must be documented in an (event) incident report and reviewed by a QMRP. The QMRP review should include discussion with the participants regarding the incident and how it might have been prevented. If restraint is used on more than one occasion, its use must be reviewed by the regional office or habilitation center Human Rights Committee. If physical restraint is used more than once with an individual, all further incidents involving the use of physical restraint with that individual must be reviewed by the Human Rights Committee. If there are more than three incidents of physical restraint in a six-month period, the person's support team must reconvene to determine how to increase the effectiveness of that person's

behavioral support. This may involve revising the strategies, providing more staff support or additional training, doing further functional assessment, or making changes in staff, residence, day program, etc.

Medications

The right medication, given for the right reason, can be enormously helpful in making life more livable for the individual. Sometimes medical or psychiatric conditions can be the cause of various behaviors. Medications for some of these conditions can be beneficial and it would be negligent of us not to support the person in pursuing treatment under these circumstances.

Sometimes medication is not the best answer. Drugs have side effects, particularly when used in combination with other medications. Some of these side effects can significantly lessen the person's quality of life.

> ***Medication must never be used as a substitute for teaching the person more effective ways of reaching their goals or as a way to make our lives easier or to "control" the person.***

We must not encourage the person to take a medication which will have an effect on their behavior without first informing the person. We cannot tell the person that the medication is for another purpose when it is being administered for its effect on behavior. The person has a right to be informed about the recommended form of treatment, to know why it's being recommended, to know the side effects and alternatives, and to refuse to take the medication.

The four emergency procedures that we have described are not clever, not long-lasting in their effects, and, most importantly of all, they are not "interventions", given our definition that interventions must involve teaching new skills that replace problem behavior over time.

When the emergency is over, it is essential that we begin planning and take advantage of the quiet period. We want to teach skills that make problem behavior unnecessary and new crises rare. Ironically, the best time to implement an intervention for problem behavior is when no problem behavior is occurring.

Emergency situations can generate a lot of strong feelings on the part of both staff and the person -- feelings like anger, frustration, fear, and anxiety. This is particularly true of situations that staff believes require physical interventions. When this happens, we need to make a renewed commitment to understand how the person wants to be supported, to understand what the person is communicating with their behavior, and to teach more effective ways for the person to reach their goals. It is also helpful for staff to have an opportunity to de-brief after the experience to talk about the experience. This can be an

opportunity to problem solve: to figure out what worked and what did not. It can also be an occasion to think about what kinds of support staff need. They may need to feel safe, to know what to do in an emergency, and how to reduce the likelihood of an emergency in the future. Sometimes, we've done all we know to do and there are still emergency situations. **Staff needs to know when they have done the right things.**

Evaluate the Effectiveness of the Intervention

After we have been implemented any intervention strategy designed, we need to be sure to evaluate how well they are working in teaching the new desired skills. One indicator that the interventions are *not* working is the continued need to institute emergency strategies as frequently as before. Some of the considerations in determining effectiveness are:

- Decreases in the challenging behavior,
- Increases in alternative skills,
- Improves the quality of life (from their perspective), including choices, happiness, and self-managed calmness.
- Reduction of reliance on emergency procedures, and
- Meaningful outcomes for the person.

Revise

If the interventions have not been as effective as we believe possible, we need to reassess what we think, develop new hypotheses, and/or change our interventions. The person's support plan should be revised accordingly and as frequently as is needed by the person. Given a team approach, the person's support plan should indicate how frequently, and by what method, the success of the interventions should be reviewed. We also must continually evaluate the overall quality of their life and what are they being asked/expected to do which they may find aversive (or otherwise a detriment to a positive life that they value).

> ***We also must continually evaluate the overall quality of their life.***

Debriefing Strategies

Debriefing is a process that is used to follow up on what occurred before, during and after a crisis. Every emergency intervention should end with debriefing. It is a process that offers an opportunity for discovery:

- It allows all participants involved an opportunity to express their thoughts, feelings and emotions about what happened from their perspective.
- Information is gathered for the purpose of providing better supports to the person, to determine if the current environment meets the person's needs, to find ways to prevent the crisis from occurring in the future, to determine if systemic changes need to occur (such as supervision /monitoring methods in place, staff training, need for changes in staff or living environment, policy and procedure review, etc.), and to determine if the personal plan is working or not, etc.

Below are some examples of debriefing strategies:

Staff Debriefing should be done following each episode of restraint/emergency intervention, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

- Identification of what led to the incident;
- Determination of whether the individual's plan was used;
- Assessment of alternative interventions that may have avoided the use of restraint/emergency intervention;
- Determination of whether the consumer's physical and psychological needs and right to privacy were appropriately addressed;
- Consideration of counseling or medical evaluation and treatment for the involved consumer and staff for any emotional or physical trauma that may have resulted from the incident;
- Consideration of whether other consumers and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
- Consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
- Consideration of whether additional supervision or training should be provided to staff involved in the incident;
- Shall be referred for review by the behavior support committee.

Consumer Debriefing should be done following consumer's release from restraint/emergency intervention, the consumer shall be asked to debrief and

provide comment on the episode, including the circumstances leading to the episode, staff or consumer actions that may have helped to prevent it, the type of restraint or used, and any physical or psychological effects he or she may be experiencing from the restraint/emergency intervention. Whenever possible and appropriate, the staff person providing the consumer with the opportunity to comment shall not have been involved in the episode of restrain/emergency intervention.

The consumer shall also be notified of the availability to report a complaint to the Human Rights Committee or Department of Mental Health Office of Consumer Safety.

The human rights chair person shall meet with a consumer who has expressed a response to an episode of restraint/emergency intervention that suggests a possible rights violation or other harmful consequence.

Section III. Planning for Supports

Person-centered Planning Guidelines
http://www.dmh.missouri.gov/mrdd/provider/providerhome.htm

Division Directive 4.050
http://www.dmh.mo.gov/mrdd/Directives.htm

Incorporating what we have learned into the Person-centered Plan

"Person-centered planning is a process directed by the individual, with assistance as needed from a representative. It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes and the training, supports, therapies, treatments and/or other services, become part of the person-centered plan".

- ***The personal center process provides a structure for incorporating information learned into one document.***
- ***The person-centered plan describes information we need to know about supporting a person.***
- ***ACTION PLANNING - means the plan is utilized to teach staff HOW to support the person***

Including Behavioral Interventions in the Plan

Behavioral intervention should include hypothesis-based interventions.

Intervention components are *a*cquired through an information gathering process called "functional behavior assessment" planning includes the following:

- promotion of positive lifestyles (based on a person-centered approach, understanding what is most important to and for the person, developing the supports to ensure the person's needs are met),
- preventative strategies for addressing behavioral challenges (proactive methods to prevent the occurrence of behavioral challenges),
- modifications to the environment (assessment and changes to the person's environment that impact how the person and others respond),

- teaching skills to replace behavioral issues (outcomes and teaching strategies to support learning new ways to get needs met),
- effective management of consequences (understanding what *function* the behavior serves for the person, making sure consequences promote reinforcers for *positive behavior* as opposed to *problem behavior*).

Intervention strategies must clearly be linked to the functional assessment information (hypotheses / summary statements). Behavioral intervention plans must also include:

- descriptions of the behaviors of concern, goals of intervention,
- patterns identified through the functional assessment,
- modifications to the social or physical environment that may prevent problem behavior and /or increase the likelihood of alternative appropriate behaviors,
- specific behaviors (skills) to be taught and/or reinforced that will: a) achieve the same function as the problem behavior, and b) allow the individual to cope more effectively with their circumstances,
- strategies for managing consequences so that reinforcement is: a) maximized for positive behavior, and b) minimized for problem behavior,
- goals of intervention and specific replacement skills are incorporated into the individual's overall support and/or educational plan (e.g., ISP, IEP)
- if necessary, strategies to insure safety and rapid de-escalation of the individual's behavior,
- teaching self-management of behavior, such as anger control, effective socially acceptable communication, and self-determination.

We should not rely upon punishment and restraint, but rather reserve those situations for when protection is needed.

While developing and implementing the plan, including behavior supports, it is vitally important to know and understand the person. We need to understand the way people communicate, their history, the way they express anger, and frustration, their learning techniques, and so forth so we can have a positive driven, learning adapting behavior support plan enmeshed into the overall person-centered plan. Plans should clearly describe the method the individual uses to communicate, including "alternative communication methods". (See section II pages 27 – 30 of this document). The DMRDD person-centered planning guidelines also contain information and tools to assist with describing and documenting how the individual communicates.

> ***If we support people in building a lifestyle that respects their routines, helps them pursue their own personal goals, and enhances communication, we believe that most of what we call "acting out" or "behavior problems" will disappear.***

The history of the person is crucial to understanding how a person learns, how they will react to various intervention techniques, and how certain actions by us may actually exacerbate the situation.

As a staff member, it is our responsibility to both understand what is written in a personal plan, and also contribute to the accuracy of the plan. For example: If we know that certain behaviors are precursors to an aggressive episode because this is how the person expresses frustration or anger, or fear, then we need to share that knowledge. If we fail to provide positive supports, in a teaching way, then we are failing to uphold our values. The person-centered plan should describe what the person wants with their life, should describe ways for them to learn to self-manage their behavior. We cannot teach people skills by engaging them in techniques that frustrate, cause fear, belittle, or eliminate their ability to control their lives.

The purpose of the action plan is to describe an outcome and its specific activities or action steps that will be undertaken to accomplish the changes identified in the outcome statement. Action planning represents a team effort that structures the groups' commitment to work together to achieve desired outcomes. It also assists team members to share responsibilities, to identify opportunities for learning and to problem solve identified barriers.

Action planning is not static. It should be viewed as a "picture" of the planning process:

- It is based on what's important **to and for** the person.
- Outcomes represent personal meaning to the person.
- It is based on things that need to change, what does or does not make sense, things that need to be maintained and/or enhanced in the person's life, and problem solving issues and concerns.
- The person remains actively involved in the implementation of the plan.
- Action planning reflects continuous learning about the person over time and documented efforts of that learning.
- Plans should change as the person changes over time.
- There is a focus on supporting the person NOT developing "programs".

Developing Outcomes

Developing person-centered plans is a means not an end. It is merely a tool to help people to get the lives that they want. Any plan that focuses on outcomes demands accountability to the person and is demonstrated through actions. The team members are making a promise to the person. Plans must be written in accordance with the Missouri Quality Outcomes and the DMH Person-centered Planning Guidelines. They reflect best practice, and provide us with a look at outcomes that define a typical lifestyle desired by anyone. The definition of each Outcome is different for each individual depending on our current situation, life experiences, and future goals. The steps each of us takes to reach the same outcome are distinguished by our own personalized paths or journeys. For example, the Missouri Quality Outcome that states: "People belong to their community" will be defined differently depending on where you live, who you know, what you want from the community, what you want to contribute to your community and the resources available to access your community.

Using the Missouri Quality Outcomes in the process of person-centered planning will assist the person and his/her team to seek ways to enhance and/or offer opportunities for a better community life, to <u>develop valued roles</u> and to implement action and outcomes that makes sense specific to meeting the person's needs and preferences.

Using the Missouri Quality Outcomes to develop outcomes:

Missouri Quality Outcomes:
- People belong to their community
- People have control over their daily lives
- People have a variety of personal relationships
- People have the opportunity to advocate for themselves, for others, and for causes they believe in.
- People have valued roles in their family and community.
- People's plans reflect how they want to live their lives, the supports they want, and how they want them provided.
- People are connected with their past.
- People live and die with dignity.
- People's communication is understood and receives a response.
- People feel safe and experience emotional well being.
- People are provided behavioral supports in positive ways.
- People are supported to attain physical wellness.
- People are provided support in a manner that creates a positive image.
- People are actively supported throughout the process of making major lifestyle changes.
- People express their own personal identity.
- People are supported in managing their home.

Note: When utilizing the Quality Outcomes as a means to develop personal plan outcomes, the plan facilitator must understand the purpose, intent and values of the outcomes in order to successfully facilitate the action planning process. *Please see reference to the Missouri Quality Outcomes in the introduction section which outlines the general purpose, values and assumptions.* Additional information is also available at:
http://www.dmh.mo.gov/mrdd/QA/qahome1.htm

Understanding the purpose of developing outcomes and its relationship to QUALITY OF LIFE (i.e.: meaning of personal outcomes, developing valued roles, outcomes to reflect problem solving, etc.) includes:

- Understanding what's working (or making sense) vs. what is not working (or not making sense) in the person's life and support.
- Defining the current situation / rationale.
- Identifying barriers and opportunities for learning.

Some things to think about as you develop strategies to implement outcomes:

Successful Strategy components tell us:

- How the person learns best.
  What is the person's learning style? For example: What type of environment is best for teaching and learning based on the unique needs of the person (i.e.: lighting of a room, noise level, time of day, location, etc)? What are the characteristics of the "teacher" or "supporter" that will best support the person to learn (i.e.: tone of voice, body language, and overall demeanor)? Do supporters know how to teach from the person's perspective? How much do we need to "break down" a given task? Are we realistic about how long it may take for each individual to learn a given skill?

- What we will do, teach, or support.
  Are action steps meaningful to and for the person? Do supporters understand the *rights* of the person they are supporting? Do the support strategies work for the person vs. for the supporter? What are the specific *support* strategies (instructions / description of the supporter's behavior) that the supporter *must* follow for each action step? Do the strategies describe *how to teach?* Are the support strategies written in a way that any supporter can follow? Is teaching occurring in the *natural environment?* Do supporters understand the use of *reinforcers* so that the person *connects* the response to the reinforcement? Do supporters understand the importance of and how to deliver reinforcers?

- How to implement action steps.
  Do the supporters have "buy-in" in the implementation of the action steps; understand the intent behind the learning and what they are expected to do?

- How to tell when the outcome has been accomplished through measuring and documentation.
  Do supporters know what and how to reflect that the action step has been addressed in their documentation? It is helpful for supporters to have a set of questions to answer so that the documentation is meaningful in measuring progress (for example: Where did teaching occur? Who was present? A description of the activity. How the person responded. What the person learned. What are is being learned about supporting the person? What adaptations were made to better support the person during learning? What worked? What did not work?)

- Who is responsible for implementing each strategy
  Is their accountability to assure action steps are addressed? Who is following up and assessing if the outcome / action steps are working for the person?

- Timelines (be realistic but also have a sense of urgency) for when strategies need to be accomplished. These should be tied to Action Steps. Is implementation and estimated completion dates clear? (i.e.: date to begin, target date). Do the start and estimated completion dates make sense for the specific action step and meets the person's specific needs for learning? (For example, how long should it take to help a person to learn a new skill, to access his/her community, to visit with family/friends.)

EVALUATION AND DOCUMENTATION OF OUTCOMES

The team will need to track changes in the consumer's target behaviors and evaluate lifestyle changes that occur as a result of interventions. Documentation of progress is essential to determine effectiveness of the person's plan and must be tied directly to the outcome/action steps. If minimal progress occurs with decreasing behavior, increasing new skills, or enhancing the consumers quality of life, the plan and the assessment, should be reevaluated. It may be necessary to repeat or expand the information gathering process or adjust interventions.

Some things to think about as you evaluate progress follows.
Is the person learning? Is there flexibility for the person who is learning (for example: the person may not want to work on a given action step on a given day, or maybe the person no longer has interest in what is being taught. This should indicate to us that a change needs to occur and the team needs to reconvene to meet the person's needs. Is there an assessment of what is working vs. not working for the person? We must assure that the things that are working are maintained (for consistency). We must also assure that the things that are not working change to meet the urgency of the person's needs and to avoid creating frustration for the person. Often it is our lack of urgency, our lack of consistency, lack of training and our lack of *listening* that contributes to the likelihood that behavioral problems occur. Are we evaluating the person's response to learning in addition to the supporter method for teaching? Are we assessing what we have learned about the antecedents and consequences (what happens before and after the "behavior" occurs)? Are we making changes (adaptations to the environment, for example) immediately to prevent the occurrence of behavioral problems? Do the outcomes promote a positive lifestyle based what is important *to* and *for the person?*

> **The good –** *developing and implementing the plan*
> **The bad -** *No Planning, or a plan and NO implementation*
> **Ugly-** *Poor planning, disrespectful planning, No Planning, No implementation*

Section IV. Policies and Procedures

The Division of MRDD has a variety of safe guards in place that ensure that individuals who need behavioral supports are safe and their rights are being upheld. A description of DMRDD policies and procedures follows.

Behavior Support Review Committee

The Department of Mental Health Department Operating Regulations provides specific policies and procedures that state agencies must follow or develop. As stated in part B of DOR 4.145 on the use of Restraint and Timeout; If a consumer's plan includes restrictions as a part of the behavioral interventions then the plan must undergo reviews to ensure that the plan has supporting evidence that this level of intervention is needed, and to monitor the interventions that are being used to ensure they continue to
be appropriate. DOR 4.145, Section B states:

"The facility or center behavioral support committee, client rights review committee and the client's parent or guardian as appropriate shall review and approve the plan before implementation.

Each facility and regional office shall have a behavioral support committee with representation from administration, medical service, nursing service, client or client rights review committee or board and other persons as may be designated by the head of the facility or Regional Office.   The behavioral support committee shall:

> (A) Review the utilization of restraints on a monthly basis;
> (B) Review annually the facility policies on restraints and time-out procedures to determine their effectiveness and recommend any changes to the head of the facility or Regional Office;
> (C) Identify and approve physical restraint procedures for use in the facility or "Regional Office."

Consumer Rights Committee

Contractors having a licensed, certified or accredited residential capacity of ten (10) or more consumers shall appoint a consumer rights committee, whose function shall be to review existing and planned programs, ensuring that legal rights of consumers are upheld as specified in RSMo630.110. This committee shall consist of no fewer than five (5) adult individuals, one of whom is a representative of the Regional Office. Per PART II of the DMH Contract; this group should be familiar with the rights of consumers receiving services from the Division of MRDD. It is also recommended they keep documentation related to their review of agency programs and any other meetings they may hold.

Restraints and Seclusions

The Division of MRDD is currently in the process of developing a rule which will address behavioral supports and interventions. It will include requirements around the use of restraints and seclusion. At this time all non-licensed (Accredited or Certified Agency) who have a contract with the Division shall comply with the Division's policy and procedures as outlined in Part II of their contract with the Department of Mental Health which reads;

"All contractor facilities which are not licensed by shall comply with policy and procedures regarding the following: Admission Criteria, Treatment Planning, Seclusion, Restraint and Time-out."

Reporting Rule

All staff providing supports for individuals should be familiar with the Rule for Reporting of Events 9 CSR 10-5.206. There are a number of events related to behavior that must be reported. Some of these include; physical altercations between consumers; physical altercations between staff and consumer; physical altercations between consumer and non-staff, elopements, sexual conduct, and suicide attempts. Any event that may result in the use of a restraint, administration of a PRN psychotropic medication, admission to hospital, and any event where there is an allegation/suspicion of abuse neglect must be reported. Consumer Self Harm and Graphic Threat of Harm should be reported only if they are unusual and not being addressed in the personal plan; there is an injury; or there is an allegation/suspicion of abuse or neglect.

Definitions of Reportable Events Related to Behavior as defined in 9CSR 10-5.206:

Elopement: When a consumer's absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return. (Record return date and time.)

Physical altercation between consumers: Any physical force inflicted upon a consumer by a consumer.

Physical altercation consumer & non staff: Any physical force inflicted upon non-staff by a consumer.

Physical altercation – staff & consumer: Any physical force inflicted upon the other when an altercation occurs between a staff and consumer.

Sexual conduct - consumer/non-consensual: Any sexual act involving a consumer when it is suspected or alleged that one of the parties was not a willing participant. This includes those incapable of giving consent due to guardianship or other reasons.

Sexual conduct – staff & consumer: Any suspected or alleged sexual conduct between staff and consumer including but not limited to the definition of sexual abuse.

Suicide attempt: Any action(s) taken by an individual with the intent to kill oneself but he/she is not successful.

Report the following incidents only if:
1. unusual and not being addressed in the personal plan;
2. there is an injury; or
3. there is an allegation/suspicion of neglect.

Consumer self-harm: Any physical force inflicted by a consumer on self.
Graphic threat of Harm: Any threat, verbal or non verbal, which conveys a significant risk of imminent harm or injury and results in reasonable concern that such harm will actually be inflicted.
Seizures: A convulsion or attack of Epilepsy.

Staff Training

Positive Behavioral Support Training - Is a requirement for staff of DMH contracted providers.   All staff must receive training in an DMH approved Positive Behavioral Supports curriculum within 90 days of employment, if they are providing any of the following services; Day Habilitation, Residential Habilitation, Agency Based Personal Assistant, Out of Home Respite, or Supported Employment Services.

Training on use of Restraints - Not all staff will need this training, however if the consumer's plan requires that they be supported by staff who know how to perform a restraint then the staff must have completed a course approved by DMH. Currently these are MANDT or NCI training.

Section V: Gentle Teaching

Overview
One significant change in best practice over the past few years is the shift to "gentle thinking". Gentle Thinking, called by many names, is rooted in the philosophy of Gentle Teaching, which was developed by John McGee. In Gentle Teaching, there is an assumption that people who have an intellectual disability, and who exhibit severe behavior problems, have not developed bonding. This means that they lack "mutual ties of affection resulting in the positive value of human presence, participation and reward". This can be seen as parallel to a complete failure to meet the needs of 'love and belonging' in Maslow's Hierarchy of Needs.

Bonding, or the feeling of being a loved and worthwhile member of a family or group, is seen as essential for learning of socially desirable behaviors. Such learning proceeds through 3 phases - learning the value of:

1. HUMAN PRESENCE - this is the antecedent of all behavior. We need to learn that human presence signals safety, security & reward, not frustration, punishment or threat.
2. HUMAN PARTICIPATION & INTERACTION - this is the actual behavior necessary to learn that reward is the result of our behaviors with other people, that by participating and interacting we gain a sense of pleasure, and a belief in the mutual value of people.
3. HUMAN REWARD - the sense of pleasure from being in contact with others. This is (or should be) the result of the majority of all our interactions. It is certainly the motivation for social beings to interact. A second key assumption is that all teaching, learning and behavior change is a mutual and reciprocal phenomenon i.e. behavior change is not something to be done to somebody; it is something we attempt to do with somebody. It is a two-way affair that can either strengthen our humanity, or weaken it.

One of the main values which affect our interactions with people who have an intellectual disability is our attitude regarding authority. On one extreme end of the spectrum is the posture of authority. This springs from a need for power or control, and uses repression to achieve conformity. The unwanted goal we achieve from this posture is that of dependence and alienation. People who engage in behavior change programs that are done to someone else are acting largely from this stance.

The other end of the spectrum is a 'collaborative' posture. This posture comes from a belief in trying to live as equals and in harmony with each other, uses concern for the well-being of others, and emphasizes mutual respect. The

outcome of this posture is one of respect for ourselves and others, and satisfaction in our interdependence (i.e. having our needs met while meeting someone else's needs).

The other dimension of importance is that of warmth vs. distancing. This refers to our interest (or lack thereof) in the emotional state, experiences and self-image of those with whom we come into contact.   This, combined with our posture on authority, leads to one of four interactional postures which determine how we relate to others. These are:

INTERACTIONAL POSTURES

OVER PROTECTIVE
- Non-developmental/ infantilization
- Smothering care
- Victimizing

SOLIDARITY
- Focus on respect
- Centered on inter-dependence
- Protection without smothering
- Focus on acceptance, tolerance, warmth

Warmth

Dependence   **Independence**

Distancing

AUTHORITARIAN
- Repressive
- Punitive
- Focus is on behavior elimination

COLD
- Mechanical
- Focus on compliance
- Disregarding/disinterested
- Focus on orderliness/lawfulness

Professional care givers generally believe that they treat people who have a disability in helpful ways. However, research shows that we often teach compliance (obedience) rather than mutual respect and interdependence. In one piece of research we see that most "teachers" directed and corrected behavior on average 8 times more often than they gave rewards. That is, the professional care givers paid more attention to unwanted responses than to the wanted responses. Thus, people initiating desirable behaviors received far less attention than those showing unwanted behaviors, or those who made mistakes in what they did.

However, Gentle Teaching does not suggest that we focus on merely rewarding correct responses, but on teaching and rewarding <u>reciprocally rewarding responses</u>, those that indicate positive personal interaction and cooperation between the support person and individual who has the disability.

In summary, to prevent and defuse challenging behaviors, and to aid development of people who have disabilities, we need to adopt reward-centered teaching and support practices rather than perpetuating correction and compliance focused practices. There is more information about Gentle Teaching in the appendices but more importantly, the premises of Gentle Thinking are woven throughout this revision of this book.

What Staff Should Know About Gentle Teaching

John McGee, the primary proponent of Gentle Teaching, makes no pretense of Gentle Teaching being an easy answer to complex problems. This philosophy offers no recipes and views many of the "old school" strategies and modalities as oppressive. Gentle Teachers are often in the position of "figuring it out" based on their intimate knowledge of the person served and Gentle Teaching principles. This usually occurs when times are most difficult.

> *In "Mending Broken Hearts" McGee writes:*
> *"The act of caregiving starts by concentrating our efforts on two initial tasks – eliminating in ourselves whatever the person might see as domineering and elevating our expression of unconditional love to the highest level possible. For those who are fragile, many modern caregiving practices are seen as mean-spirited, neglectful, and even abusive; verbal reprimands, physical restraint, time-out, token economics, suspensions and a host of other common strategies."*
> *(McGee, 1999, p.2).*

Gentle Teaching requires a level of personal involvement most other approaches try to avoid. McGee believes we must be willing to initially and constantly look at ourselves. Introspection, self-awareness and substantial emotional self-mastery are necessary groundwork for genuine unconditional acceptance of others. McGee further states:

"When in doubt about what to do, a gentle caregiver looks at any question or situation from this perspective – what will help the person feel safe and loved at this very moment? Instead of worrying about issues like compliance, independence, or self-determination, the gentle caregiver is concerned with teaching children and adults to feel safe and loved. Rather than fixed answers, we have to examine ourselves and our values – especially nonviolence and the ability to express unconditional love in the face of violence and rejection." (McGee, 1999, p.3). All emphasis added.

Achieving mutual feelings of companionship with the person served is a primary goal. Companionship rests on four pillars that McGee calls the "central purpose of caregiving". They include teaching others to feel SAFE, LOVED, LOVING and ENGAGED in relation to the caregiver.

Teaching others to feel safe with us requires substantial understanding of the nature and depth of their fears. This understanding is often difficult to gain among friends and coworkers. It becomes extremely challenging in regard to people whose life stories entail chronic disability, persecution, and institutionalization. The Gentle Teacher strives to understand how he is viewed by the person served and is willing to adapt himself to make the person feel safe with him.

61

The second "pillar" on which companionship is built is the feeling of being loved. The feeling of being loved, as one of the most basic human needs, has the time-tested support of numerous major figures in the field of human behavior (e.g. A. Maslow, C. Rogers, W. Glasser, P. Breggin et al.); not to mention the support of virtually all the major world religions. It involves a sense of self-esteem and worth. For a person whose basic attachment to others has been stunted or severed by trauma, chronic disability, revolving caregivers, or other tragic circumstances; feeling of isolation, fear, and meaninglessness can pervade their being. Such a person may withdraw or even seek domination of others. Teaching this person a feeling of being loved requires giving love to them abundantly and unconditionally. Caregiver expressions of valuing must continue through what often seem like severe tests of our limits of acceptance.

Teaching the third "pillar", to feel loving, is an extension of the first two. It is a maturing of feeling safe and loved. Gentle Teachers, having consistently modeled expressions of safety and love, may begin to softly invite reciprocation. Recognizing the person's first subtle expressions of warmth such as smiles, kind words or affectionate touches move the process forward.

With the integration of feeling safe, loved, and loving into one's being comes meaningful engagement with others. The valuing of self and others is reflected in the development of one's own abilities and their incorporation into more positive participation. The scale of this participation is appreciated according to each person's capacity. For one it may be social activism, for another it may be improved family relations.

Proponents of more controlling approaches to care giving often claim their techniques work. Translated this typically means that the person became quieter, more passive and cooperative. **Gentle Teaching states this apparent success is merely fear-based compliance, convenient and even profitable for the care provider, but serves to drive the fragile person further away from connection with others and an acceptance of self.** In contrast, engagement is based on trust that is cultivated through the Gentle Teaching process. The participation springs from a sense of self-value and belonging.

The "tools" used by Gentle Teachers are so basic, their profound impact on others is often overlooked. The tools are hands, words, eyes and presence. The manner in which we use our hands to touch others has powerful potential for communicating safety and acceptance. Careful consideration must be given to the person's vulnerability to the misinterpretation of supportive touch. Even in lives without history of physical or sexual abuse, there has often been physical restraint or control at the hands of past caregivers.

Constant attunement to the person's emotional state is critical. **As McGee says "Words are more than words. They are like our hands that need to reach out to and uplift the troubled person."** (McGee, 1999, p.20). He also

points out that they can be intrusive and demanding as well. Our words (including tone, rhythm and pace) should be a near constant source of valuing and support. Powerless people are hyper-vigilant to changes in tone and inflection that can be the first evidence of a strained caregiver.

> ***Gentle Teachers avoid those common behavior- modifying phrases such as "You know better than to…" and "That is inappropriate".***

We are all contagious. We are all affected by the quality of each other's presence. This is a subjective experience but we can begin to identify qualities that tend to uplift and reassure. For example, smooth soft sounds and movements at a relaxed pace with predictable rhythm can help ease agitation and fear. **The more unsettled the person; the lower and slower our tone and pace should become.** A steady flow of warm, non-demanding attention to the person creates an even deepening impression that it is good to be with us.

In a multitude of subtle ways, the quality of our presence reflects our emotion state, how we see ourselves and how we see the person. See a picture in your head of yourself entering someone's home as his or her guest. You respect this person and want to make a pleasing impression. How would you move and speak? How would your mannerisms reflect your value of the host and your desire to be viewed in a positive light? Contrast this with seeing yourself walk into a room where there are people for whom you have contempt. You want your entrance to reflect you own the place! How has your presence changed? We are all masters of our presence to the extent of our self-awareness. How does it feel to be with you?

> ***One frequent misconception of Gentle Teaching is that it is negligent to caregiver safety. This is not the case. The first rule of Gentle Teaching is:***
> ***<u>"Harm comes to no one"</u>.***
> ***However, inherent in the choice of being a caregiver***
> ***Is acceptance of a certain level of risk above that of***
> ***most professions. In society at large, we tend to***
> ***protect ourselves first and at all cost.***
> ***Gentle Teachers are obligated to seek safety <u>for all</u>.***

One of fear's many faces is aggression, which is a desperate attempt to feel safe by controlling the environment. This applies equally to the care giver and the person supported. Primary responsibility for peaceful resolution in critical moments is shouldered by the caregiver. **Caregivers with hair-trigger fight or flight reactions will damage relationships and increase risk of harm through over-control or provocative defensiveness.** Preparation is imperative. The quality of relationship is the foundation of safety. Every interaction between the caregiver and the person served has a cumulative impact on the course of critical moments.

Knowledge of the person and constant attunement to his/her emotional state is critical as guides for the ebb and flow of our interactions. Attention to the environment (e.g. dangerous objects, exits, etc.) and pre-planning with the person served promote safety. (A note of caution: this can also be done in such a way as to establish an expectation of violence that may create a self-fulfilling prophecy.)

Gentle Teachers are dedicated to promoting safety without control and to evoking peace. This commitment emanates naturally from a genuine sense of companionship.

Core Knowledge and Issues

Gentle Teaching is a guide for those who care for and about others. Often, people supported by Gentle Teachers are people whose lives are profoundly compromised by illness, emotional trauma, and socio-economic conditions. Its principles apply as well to care giving in our personal lives as they do to professional care giving roles. In fact, from a Gentle Teaching perspective, it is the "professionalization" of care giving that often perpetuates the fear, isolation and even oppression of those served. For example, withholding various forms of valuing (i.e. smiles, gifts, praise, etc.) in response to non-compliance with a treatment plan is seen as a means of domination that not only does violence to fragile people but also misses the point. The point being, people need to feel safe and accepted as a prelude to genuine personal change. Therefore we must not focus on superficial behaviors but rather, on the core of the human condition, not the broken brain but the broken heart.

To fully grasp the basis of Gentle Teaching one must recognize how the process of positive human development relies on having a sense of being unconditionally valued by others. This sense comes about through deep feelings of connection and companionship with others that begins to support a basis for self-acceptance. It is this foundation of safety and belonging that provides some relief from the preoccupation with fear, isolation and meaninglessness that underlies most of what are typically labeled as "symptoms".

Gentle Teaching is not a set of treatment interventions applied strategically to a client but rather <u>a way of being with a person in distress</u>. Its goals are **not** primarily to modify behaviors, extinguish symptoms, or build skills. Instead, Gentle Teaching seeks to cultivate a sense of safety and security and feelings of warmth and companionship between the caregiver and a person who may be distressed, fearful, and socially marginalized. The caregivers then have a moral obligation to become a bridge between those persons served and others, aiding in the development of meaningful and supportive relationships. This process helps establish a "culture of life" that hopefully leads to a true sense of community. The goals of most conventional approaches (i.e. behavior modification and skill building) *are actually more readily achieved as by-products of the process of Gentle Teaching* as people begin to feel more safe, loved, loving and engaged with others.

SOME DO'S AND DON'TS OF GENTLE TEACHING

<u>DO'S</u>

1. Use a task as a vehicle for participating with the person. Do the task with the person. During difficult times, do the task <u>for</u> the person.
2. Talk to the person. Tell stories, jokes; share your thoughts and feelings. Be warm and soothing, but most importantly, be genuine.
3. Give smiles, handshakes and hugs. Save your touches for human valuing.
4. Ignore non-participatory interactions. Adjust your positioning to minimize risk of injury to the person and to yourself.
5. Control the environment and the task materials. Prepare for the time to be spent with the person.
6. Go where the person is, physically, emotionally and intellectually. If the person is lying on the floor, start there!
7. Elicit smiles, hugs and touches from the person. Teach them how to give human valuing.
8. Value the person non-contingently.

<u>DON'TS</u>

1. Issue orders and commands.
2. Assume the person knows better.
3. Grab, restrain, reward continently, or punish.
4. Attempt to control the person.
5. Place yourself above the person.
6. Limit dialogue to the task or to concrete topics. Feel free to talk about love, hope, friendship and other abstract ideas.
7. Allow the person to push you away with non-participatory interactions. Cut through the <u>garbage</u> with patience and persistence.
8. Stop talking! Don't react to the distancing interaction any more than absolutely necessary. Never ignore the person.

Persons who have been institutionalized or isolated likely need to learn social skills that will help them participate in activities, first with instructors and caregivers, and eventually with others.

Gentle Teaching Key Strategies

Gentle Teaching is hard work, partly because each interaction between two people is unique. As such, no precise strategy can be applied to all situations. The following are some general strategies to consider in trying to prevent challenging behaviors from occurring in the first place, or for reducing their frequency, intensity, or duration.

- **Precursor behaviors** - e.g. ensure that nothing "throwable" is in reach if the person uses throwing as an inappropriate form of communicating.
- **Environmental management** - e.g. sit beside or behind a person who engages in self-injurious behavior (SIB) so that their hands can be shadowed and controlled to prevent SIB, or sitting on the other side of a table (out of reach) from a person who is likely to hit.
- **Stimulus control** - set up the tasks before the person so as to ensure on-task success through the consideration of factors such as the arrangement of the tasks, control of materials, concreteness of the task, teaching methods, location, etc.
- **Errorless learning** - break learning skills into a small steps and place in an order that helps the person learn, and provide adequate assistance in order to avoid errors (so that structured tasks can serve as vehicles to teach reward throughout the day).
- **Teach quietly** - initially using minimal verbal instruction maximizes the power of verbal reward, and prevents on-task confusion. Gradually use more language as the reward - learning cycle takes hold.
- **Shaping and Fading** - use the caregiver's initial intense presence, necessary assistance and reward teaching as a way to ensure as much as possible the person's on-task attention (shaping), and then as rapidly as possible remove the external assistance and reward so that the person will remain on-task and be able to receive sufficient reward from the task itself (fading).
- **Assistance** - initiate learning with a sufficiently high degree of assistance to ensure success and systematically and rapidly decreasing the degree of assistance, but be ready at any given point in time to offer higher degrees of assistance for purposes of redirection or reward-teaching.
- **Using the task as a vehicle, not an end in itself** - each part of the day needs structuring so that there are opportunities to create rewarding interactions - we cannot wait for these opportunities to present themselves. ***But the task of learning is <u>secondary</u> to the teaching of rewarding interactions.***

- **Gentle Intervention:** The basic paradigm in Gentle Teaching is based on Differential Reward of Alternative behaviors. It involves three core elements:

  1. Ignore/Interrupt
  2. Redirect
  3. Reward

These steps are meant to occur as a dynamic process, not as separate components. Ignoring or interrupting a behavior should occur over a period of seconds, and lead into redirection to a positive task or activity, where reward can be, and is, freely given.

The following outlines the basic strategies which can be used to follow this pattern.

Step 1: Ignore Distractive or Disruptive Behaviors Without Ignoring the Person:

In Gentle Teaching this means avoiding or minimizing the negative attention, punishment or restraint that typically occurs during or following a maladaptive interaction. It does not mean ignoring the person. The aim of this intentional ignoring is to defuse challenging behavior and take away the power that the behavior has. To ignore involves withholding threats, reprimands, "scolding's" and statements of rules or consequences. There are no (or at least minimal) positive, neutral or negative verbal or non-verbal attentions to the behavior itself, BUT the person is immediately re-directed to a task where reward can occur. This should only occur when harm is likely to people or property. If it is necessary once, we should focus on future prevention. The aim of interruption is to prevent harm while continuing to teach/support. Interruption should be minimally intrusive, and conducted in a calm and warm manner.

Step 2: Redirect:

Redirection is the main component of the Gentle Teaching process. It focuses the interaction on acceptable alternatives to inappropriate responses. It also communicates that the inappropriate response is no longer effective, while providing clear information that an alternative response will result in a rewarding interaction. In redirecting it is important to use minimal cues (e.g. non-verbal), thus avoiding the possibility of reinforcing the inappropriate behavior. **Redirection may require several patient attempts.** Once any attempt at participation in the redirected task (or activity or conversation) occurs, the care giver should provide reward (i.e. shaping a desired response).

If the redirection effort fails to lead to a positive/desired response, the care giver can repeat it, or use a hierarchy of prompts (pointing, touching the learning material, placing it nearer, guiding movements) - such prompts must be specific and consistent. The process of redirection should be as brief as possible, to prevent the person gaining reward from inattentiveness.

Step 3: Reward:

Use sincere, meaningful verbal and non-verbal means of communicating your pleasure. Edible rewards do not help teach the value of <u>social reward</u>, which is one of the main aims of Gentle Teaching. You may choose to reward at any point (or all points) of a task: the initiation, participation, or completion.

Gentle Teaching Examples - Some Things You Can Try

If the person tries to hit you:

- Protect yourself as non-intrusively as you can, for example: by blocking the hit with your arm;
- Generally say nothing about the hit;
- Firmly, calmly and fairly redirect the person to a task/preferred activity;
- Help the person return to the task/preferred activity with cues, physical assistance, etc.;
- Give concrete goals to the person;
- Give strong reward for engagement in or completion of task/preferred activity.

If the person is beyond redirection at the moment, or "in a fury":

- If possible, in a firm but fair manner, try to redirect the person to a task/preferred activity;
- if not, protect yourself, the person and others through environmental or physical control until the fury subsides;
- During the fury's peak, do not chastise the person, remain calm and soothing;
- As the fury subsides gently redirect the person to a task or activity;
- As he/she redirects, focus on gaining interactional control;
- Focus on prevention by identifying the precursors which lead up to the fury;
- In the future redirect the person as these precursors begin to appear.

If the person is working up to a "fury":

- Identify the behavioral and physiological signs (precursors) which lead up to a possible fury as a preventative measure;
- Given concrete instructions to the person in the form of a goal -- "Let's do _____one more time";
- Remove unnecessary stimuli from around the person;
- Help the person meet the goal (succeed) through verbal or physical assistance;
- Take a short break with the person;
- As the signs subsides, gently redirect back to the task/preferred activity.

If the person is self-stimulating:

- If it does not interfere with learning, ignore it;
- If it interferes, find a way to prevent it or block it;
- If hand or arm waving, use task which require the use of both hands;
- Use tasks which require a relatively fast pace;
- If the person rocks, arrange the seating or table position to reduce it;
- Perform the task standing up if necessary.

If you are afraid to have the person go to school, work or live with others:

- Teach sharing to all who live, work or go to school together;
- Re-evaluate the need and purpose of their attendance and seek alternatives.

If the person refuses to participate:

- Make sure there is a logically structured flow to the day;
- Make sure care givers are not encouraging such behavior;
- Once refused, try to take the person gently by the hand or arm;
- If the person is cooperative, proceed with the person reinforcing the cooperative behavior;

If the person still refuses to participate:

- Give the instructions again;
- Make the task/activity easy and reward <u>any</u> approximation towards participation;
- Do not get into a "tug-of-war";
- Remain near the person giving no eye contact or verbal input other than periodic gestural or verbal redirection;
- Use a visual cue representative of the task or activity;
- Be prepared to do this for 30 to 60 minutes;
- Make sure no one else interferes.

If the person runs away from the classroom, workshop or home into a dangerous situation:

- Quickly catch up with the person in as non-conspicuous a manner as possible;
- Attempt to block their further progress unless this were to result in a physical confrontation;
- Redirect - "Let's sit down," "Let's go for a walk," "Let's look at"...

- If necessary, hold the person by the hand or wrist in a gently reassuring manner;
- As soon as the fury subsides, return to the appropriate place;
- Establish concrete goals -- "I will help you do five, then we will take a break. Let's go out the back and play on the trampoline."

If the person throws objects:

- Prevent through environmental and stimulus control in the future;
- Work quickly for interactional control;
- Gradually lessen the environmental control.
- Proceed with the task ignoring the thrown objects on the floor;
- Don't make the person pick them up;
- Have enough materials available to you so you can proceed;
- Avoid using such punishing consequences such as overcorrection, retribution, etc.

If the person punches his/her face:

- Initially sit face-to-face with the person --- their legs between you while teaching a task;
- Carry out programs in this position;
- If possible, gently physically redirect the person to the task as he/she attempts to strike a blow;
- If this causes a tug-of-war, shadow the blows-allowing the person to strike your hand;
- Say nothing while redirecting with gestures.

If the person talks incessantly, inappropriately or screams:

- Ignore - say nothing, do not look at the person;
- Redirect the person to the task verbally or with gestures;
- Indicate when you will speak with the person;
- At that time, direct the conversation;
- Reward the person for appropriate conversation.

If the person ruminates food:

- Keep a towel handy;
- Ignore while redirecting to the task;
- Clean self or person as necessary;
- Watch your seating arrangement to avoid being spat on;
- Emphasize tactile praise.

If the person tries to eat dangerous objects (pica):

- Be cautious through stimulus control;
- Present tasks initially shadowing the person's hand movements to block the possibility of the person putting objects in his/her mouth;
- Emphasize tactile praise;
- Use stimulus control and shadowing techniques;
- Fade these as interactional control emerges.

If the person bangs his/her head:

- If previously used, eliminate helmets, masks, strait jackets, etc.
- Focus on intensive developmental programming;
- Position yourself and the person to prevent head banging, if necessary away from walls, table tops, arms of chairs, etc;

If the person talks in a disassociated manner but at the appropriate time and place:

- Politely break into conversation;
- Indicate that you will not talk on the disassociated topic;
- Reinforce conversation that is appropriate to the time and place;
- Make sure others are consistent in this approach because it is easy to accidentally reinforce "funny" conversation.

If the person is depressed - withdrawn, slovenly, possibly regressing, crying, and non-verbal:

- Be especially gentle;
- Become their emotional structure - schedule their day, set up concrete, attainable goals, etc.;
- Use verbal and tactile rewards;
- If necessary, use exaggerated verbal and tactile rewards;
- Use necessary physical assistance as a way to _sooth and reassure_ the person;
- Avoid delving into the causes of the depression with the person;
- Examine causes with significant others;
- Ensure supportive stability in their lives.

If the person is functionally capable of independence but is behaving in a way that is a danger to self and others:

- Take a firm posture;
- Structure their day - setting rules and limits;
- Give adequate supervision;
- Expect three to five years of such structure and supervision.

If you think your work is in such a poor setting that Gentle Teaching is impossible:

- Examine the needs of all the persons whom you see, and prioritize the individuals according to who most needs interactional control;
- Provide whatever number of minutes per day of Gentle Teaching, you can;
- Make sure the person has a range of activities;
- Teach interactional control to one person at a time;
- Imagine your most difficult person's bonding as a result of the care provided;
- Over time, publicly advocate for this approach;
- Organize residents, other care givers and parents to bring about positive change in the setting.

If members of the team use covert forms of punishment:

- Contact the supervisor and/or rights enforcement and/or licensure authorities as required by rule and law.

If you are short- staffed:

- Start with less complex tasks to lessen instructional time;
- Provide frequent praise to all persons;
- Set up groupings which are positively self-reinforcing;
- Use modeling of appropriate behaviors if persons go off task.

If one person fights with another:

- Given attention and praise to the person attacked;
- Ignore the attacker;
- Use your body or furniture to protect;
- Separate and redirect;
- Avoid future attacks through better environmental control.

If the person fails to respond at all or only minimally:

- Give physical assistance, if necessary, work hand-over-hand;
- Simplify the task to ensure success;
- Use prosthetic devices to help the person;
- Seek tasks which are within the person's ability;
- Gradually fade assistance.

If fellow staff members do not know how to carry out this approach:

- Spend time working "hands-on" with the person you are 'Gently Teaching';
- Have staff watch and ask questions;
- Coach them in working with the person;
- If necessary, seek outside help.

What do you do in a class room, workshop, or other group setting if the person is disruptive:

- Look for prevention techniques in the future, where he/she sits, whom with, types of work contracts or materials, etc;
- At the moment of disruption, apply the range of techniques described previously;
- Interrupt and protect when necessary.

If the person is not learning the task:

- Re-analyze the task;
- See if the task or work itself might be boring;
- If it is necessary for the person to learn, try to simplify the task;
- Sequence the tasks into simpler steps that will provide for higher rates of reinforcement;
- Provide initial assistance;
- Focus on reward as the primary teaching/training goal in the first phase of learning.

If the person gets into fights:

- Structure the person's day;
- Avoid sudden (and confusing) changes in the routine of the day;
- Focus on group work to teach socialization as well as educational or work skills.

What do you do if there is "no way" to structure the group setting:

- Look at the natural flow of the day;
- Understand that much of the home's structure can be found in ordinary transactions;
- Focus first on self-care skills and daily living skills that will reduce custody;
- Determine how much teaching or supervision you have to do;
- *Recognize these ordinary activities as potential vehicles for teaching reward.*

If this is not enough:

- Invent "sit down" programs which give, especially in the beginning, more structure and insight into the person's needs, fast run-around in terms of interactional control and some carry-over in other areas of living;
- Use the insight and practical techniques which you learn in these programs as the basis for your techniques in less structured times and settings.

If you feel that he/she will be too disruptive in a group setting:

- Place the person with a compatible mix of other persons;
- Avoid placing persons with similar needs in the same setting;
- Mix and match people's needs and strengths.

If nothing has worked:

- Examine the tasks in which the person is involved;
- Question their functionality and meaningfulness;
- Question whether you might be inadvertently reinforcing inappropriate behaviors with attention or by withdrawing demands;
- Examine the "power" of your teaching methods – especially your degree of assistance for successful task completion.

(Adapted from J. McGee et al (1987) "Gentle Teaching - A non-aversive approach to helping persons with mental retardation", Human Sciences Press, New York).

USING GENTLE TEACHING DURING CRISIS –
OXYMORON OR ANSWER?

GENERAL OBSERVATIONS

1. Crisis is not an event without cause or consequence

- Environments cause crisis behavior;
- Staff cause crisis behavior;
- Unequal power causes crisis behavior;
- Pain causes crisis behavior;
- Some unknowns cause crisis behavior;
- Loneliness and lack of relationships cause crisis behavior.

2. By the time the person is in crisis, staff have often adjusted their behavior as well.

- Adrenaline;
- Anger;
- Physiological response;
- Fight or flight;
- Control;
- Personalization (he did it to me!).

3. The consequence of escalation and crisis causes a perfect storm.

- Action-Reaction;
- Power struggle;
- Confrontation;
- Caregiver may exhibit some of the same emergent crisis behavior;
- Potential violence and lethality may increase.

At the point of crisis, the caregiver must make a critical choice:

<u>Crisis</u>

Teaching moment moment	Not a teaching
Desired Outcome	Desired Outcome
Control	Calm
Leads to imposed temporary calm	Leads to self-control
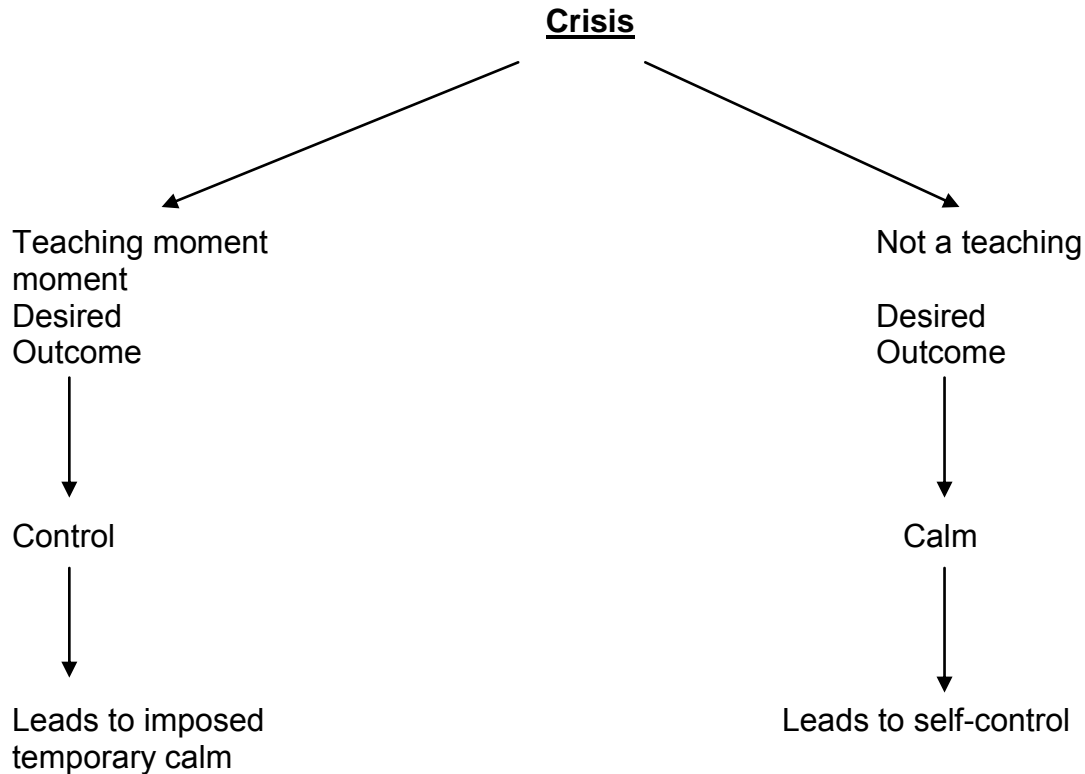
The point of decision is critical
- The gentle approach believes that crisis is not a teaching moment. We believe that violence begets violence.
- We must focus as much on the behavior of the caregiver as of those for whom we care.

---

4. Gentle Teaching is:

- Focused on being nurturing and loving;
- Helping those in crisis feel safe and loved;
- Looking at our (staff) role in teaching feelings of companionship and community;
- Mending broken hearts – broken by tragic life stories of mental or emotional disability;
- Based on the spirit of human interdependence;
- Based on <u>unconditional</u> love;
- Focuses on four essential feelings that need to be taught to those served: safe, loved, loving, and engaged.
- About human engagement – three basic feelings:
    - Good to be with another.
    - Good to do things with another.
    - Good to do things for one another.

78

5. Gentle Teaching is not:

- A traditional behavioral approach;
- Doesn't wait for the person to do "something good" to reward him/her;
- Behavior modification that uses reward and punishment;
- Using a "whatever works" approach;
- Fast and easy approach;
- A way to change the person's reality by changing his/her behavior;
- A technique.

From John McGee, Ph.D.'s website on
Gentle Teaching International

6. Most people spend most of their waking hours not in crisis – What is happening?

<u>Critical Components</u>
- Where one lives and with whom (the more difficult the behavior – the more personalized (small) the environment <u>should</u> be.
- The person must be engaged, active and stimulated during waking hours.
- The more control and optimism the person has, the more likely teaching, influence, and direction will be accepted.
- <u>Who</u> delivers the care is critical. We need to realize most caregivers (staff) are born <u>not</u> made.

Therefore, we need to look at frontline (first responders) as the critical, core and <u>most important</u> determinants of crisis prevention.
Important
- Whom we hire.
- Whom we keep.
- How we train.
- What we train.

<u>The support for caregivers is a core ingredient in the development of a crisis plan.</u>

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Appendix

An Assessment of the Psychosocial and Environmental Problems for Persons with MR/DD

Person Evaluated:		Date: Other:	
Acute Events		**Enduring Situations**	**Score**

Problems with primary support group

Acute Events	Enduring Situations	Score
Death of a family member	Illness of a family member	
Divorce/separation	Illness of housemate	
Sexual/physical abuse (recent/current)	Sexual/physical abuse	
Removal from the home	No family or no family involvement	
Major change in expectations by others (especially parents or surrogates)	Poor home staff quality/stability	
"Family" arguments	"Family" surrogate arguments	
Parental overprotection	Parental overprotection	
Neglect	Long-term neglect	
Inadequate discipline/structure	Inadequate discipline/structure	
Excessive discipline/structure	Excessive discipline/structure	
Discord with siblings	Discord with siblings	
Birth of sibling	Behavior problems of/with close family member or friend	
Change in number of family get-togethers	High Family involvement (only if problematic)	
Marriage	Ongoing martial discord	
Child removed from parent	Child removed from parent	
Marital or intimate relationship reconciliation	No identifiable friends	
Other:	Other:	

Score	

Problems related to social environment

Acute Events	Enduring Situations	Score
Major change in social activities by type or amount	Unable to be with friends except at work/organized events	
Moving to new home	Multiple temporary/interim placements	
Death or loss of friend	Major illness of friend	
Inadequate social support	No privacy	
Living alone	Intimacy prohibited	
Difficulty with acculturation	Difficulty with acculturation	
Discrimination	Discrimination	
Adjustment to change in life-cycle	Retirement, etc.	
Death of housemate	Illness of housemate	
Friend leaves shared work environment or home	Frequent "turnover" of housemates/co-workers	
New significant relationship (girlfriend, boyfriend, housemates, etc.)	Continual seeking of significant relationships with little success	
Loss of significant relationships (girlfriend, boyfriend, housemates, etc.)	Disassociative events related to abuse	
Change in home authority figures/staff	No control over lifestyle/limited choices	
Eloping	Exclusion from desired program	
Major change in church attendance/activities	Significant moral/spiritual confusion (not related to a disorder)	
Establishing intimate relationship(s)	Problems with parents/guardians/staff regarding relationships	
Pregnancy, birth of a child	Single parenthood	
Other:	Other:	

Score	

Educational/Training problems

Acute Events	Enduring Situations	Score
Starting an educational/training program	Going to school/training; extensive	
Leaving an educational/training program	Undesired under-utilization of skills	
Illiteracy	Extensive evaluations	
Academic problems	Continual poor performance in education/training program	
Discord with teachers or classmates	Discord with teachers or classmates	
Inadequate school environment/staff	Frequent program changes	
Other:	Other:	

Score	

An Assessment of the Psychosocial and Environmental Problems for Persons with MR/DD

Acute Events	Enduring Situations	Score
Occupational problems		
Unemployment	Restricted from working/unemployment	
Threat of job loss	Denied sought employment (non-workshop, etc.)	
Stressful work schedule	Extended downtime	
Difficult work conditions	Loud work environment	
Job dissatisfaction	Hates job	
Job Change	No consistent job/work	
Discord with boss/co-worker	Discord with boss/co-worker	
Change of working hours, conditions, or location	Supervisor or work group changes frequently	
Promotion or other major responsibility change	High supervision ratio in work area (if problematic)	
Employer/supervisor change (leaves workshop, etc.)	Low supervision ration in work area (if problematic)	
Loss of job		
Other:	Other:	
Score		

Acute Events	Enduring Situations	Score
Housing problems		
Homelessness	Frequent moves	
Inadequate housing	Lives in high crime area; cannot leave home	
Change in living conditions (new room, housemate, home renovations)	Sharing a residence with a person who is disliked	
New roommate	No personal/private space	
Increase in neighbor problems	Discord with neighbors/landlord	
Planning to move	Frequent or extended delays in moving	
Major change in living conditions (new home, deinstitutionalization, etc.)	Not permitted to move	
Psychiatric hospital or developmental center placement	Psychiatric hospital or developmental center placement	
Other:	Other:	
Score		

Acute Events	Enduring Situations	Score
Economic Problems		
Inadequate finances	Extreme poverty	
Interrupted income	Insufficient welfare support	
Major purchase with loan	Attachment of wages for non-payment of bills	
Repossession of belongings	No control of finances	
Major change in financial status (up or down)	On going major financial problems	
Other:	Other:	
Score		

Acute Events	Enduring Situations	Score
Problems related to health and/or access of health care system		
Inadequate health care services	Afraid of health care providers	
Transportation to health facilities unavailable	Residing in health care facility	
Inadequate health insurance	Unable to pay for/obtain medical care	
Major change in symptoms	Interference in quality of life from symptoms	
Behavior plan initiated	Behavior plan in place	
Recovery from alcohol/drug abuse	Alcohol/drug abuse	
Acute health problems	Chronic health problems	
	Requires treatment for more than one major diagnosis (including substance abuse, mental and physical illnesses)	
Other:	Other:	
Score		

Acute Events	Enduring Situations	Score
Problems related to interaction with the legal system/crime		
Being arrested	Detention in jail/prison	
Being accused	Frequent suspect	
Being convicted	On probation	
Incarceration (current/recent – short term)	On parole	
Litigation/testifying	Known to others (treated) as an offender	
Victim of crime	Involved in restitution program	
Trial, with or without conviction	Criminal record (if problematic)	
Loss of self-guardianship/other rights	Not own guardian	
Other:	Other:	
Score		
Other psychological and environmental problems		
Exposure to disasters		
War/Other hostilities	War/Other hostilities	
Discord with non-family caregivers such as counselor, social worker, physician, etc.	Discord with non-family caregivers such as counselor, social worker, physician, etc.	
Unable to get services identified as being needed	Unavailability of social service agencies	
Other:	Other:	
Score		
Total of all scores		

Evaluator Comments:	

Evaluator:	*Person Evaluated:*
Date of Evaluation:	*Data/ID:*
Other Data Required	

Page 3 of 3

Functional Behavior Assessment Observation Form

Name: _____ Observer: _____ Dates Observed - From _____ To _____

Event #	Date		Time Intervals: (Enter time intervals) ⇨							
1										
2		**Target Behaviors**								
3		List behaviors ⇨								
4										
5		(Enter event number								
6		under time intervals)								
7		**Setting Event**								
8		List setting events ⇨								
9										
10		(Enter event number								
11		under time intervals)								
12		**Antecedent**	Demand/Request							
13		List other antecedents if	Difficult Task							
14		needed ⇨	Transition							
15			Interruption							
16		(Enter event number	Told "No"							
17		under time intervals)	Told "Wait"							
18			Alone (No Attention)							
19										
20										
21		**Actual Consequence**								
22		List actual consequences								
23		⇨								
24		(Enter event number								
25		under time intervals)								
26										
27										
28		**Perceived Function**	Obtain Attention							
29		List other functions if	Obtain Item							
30		necessary ⇨	Obtain:							
31			Escape Demand/Request							
32		(Enter event number	Escape Activity							
33		under time intervals)	Escape Person							
34			Escape:							
35			Self-Stimulation							

<u>Some Questions to Consider in a Functional Assessment</u>

1. From the person's perspective, what is gained or avoided by the behavior?
2. What could be a substitute for the behavior?
3. What interventions have been used in the past, and with what results?
4. What medications are used, and how are they related to, or affect the behavior?
5. Are there medical concerns related to the behavior?
6. What choices does the person make?
7. What expressive and receptive communication skills does the person have?
8. Does the behavior occur at a certain place, time, around the same person?
9. What is the frequency that the behavior occurs?
10. What is the duration (length) of the behavior?
11. Are there current environmental events, changes, traumatic experiences, family or friend changes that may be causing or affecting the current behavior status?
12. Are there any discernable setting events?
13. Does the individual recognize that others perceive a problem exists?
14. When families are involved, what internal interactions are in place affecting the referred individual?
15. Are there other factors that may affect the behavior, such as mood disorders, depression, mental illnesses, etc.?
16. Does the person realize the expectations placed upon them and the purpose of those expectations?
17. Does the person possess the skills to perform all that is asked of them?
18. Have you looked at the situation from the perspective of the person?
19. Does the individual have a schedule that they can control, have input into, or at least predict what is going to happen?
20. Does the individual enjoy a positive quality of life from their perspective?

SCATTER PLOT

Name: _____   From: ___/___/___ to ___/___/___

Behavior:_____

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
TIME																					

A-B-C CHART

Name: _____		From: __/__/__ to __/__/__
Completed by:_____		

DATE/ TIME	ANTECEDENT CONDITIONS Include location, activity, people, etc.	BEHAVIOR Describe what happened.	CONSEQUENCES State what happened after the behavior.	INITIALS

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 1)

Focus person _____ **Date of Birth** _____ **Sex** M   F

Interviewer _____ **Date** _____

Person answering the interview questions _____

DESCRIBE THE PROBLEM BEHAVIORS.

Define each problem behavior that is of concern. Include information about what it looks like, how often it occurs (per day, week, month), how long the behavior last and how damaging or destructive the behaviors are when they occur.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Describe the person's social behaviors.

Define positive social behaviors you have observed the person perform. Include information about what it looks like, how often it occurs (per day, per, week, month) and when you are most likely to see the behavior.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Which of the behaviors described above are likely to occur together in some way? Do you see positive behaviors occurring before problem behaviors occur? Do all of the behaviors occur about the same time? If you see behaviors occurring in a sequence from least to more problematic, describe the order in which they occur.

_____

_____

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 2)

DESCRIBE ANY SETTING EVENTS THAT YOU THINK ARE ASSOCIATED WITH A HIGHER LIKELIHOOD OF PROBLEM BEHAVIORS.

Physiological Setting Events

Is the person taking any medications that may have an effect on the person's behavior?

_____

_____

Does the person have medical or physical problems that may affect his or her behavior (e.g., gastro-intestinal problems, allergies, ear or sinus infections, seizures, headaches)?

_____

_____

_____

Does the person have normal sleeping patterns or does he or she have any problems getting enough rest each night?

_____

_____

_____

Are there any dietary or eating problems that might have an impact on problem behavior?

_____

_____

_____

Environmental & Social Setting Events

Make a list of the activities where the person is successful and does not engage in problem behavior. Include the times when these activities occur.

Successful Activities   *Problematic Activities*

_____   _____

_____   _____

Are the activities on the daily schedule predictable for the person? Does the person know what to expect after one activity ends and the next begins? Is it clear to the person who they will be spending time with and for how long?

_____

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 3)

Does the person get a chance to make choices about what he or she will be doing each day? Does the person choose what to wear in the morning, the activities that she will be experiencing and when she will be able to engage in fun and reinforcing events?

_____

_____

_____

Are there usually a lot of people around at home, school, or work (including staff, classmates, family members or roommates)? How does the person respond to crowded or noisy settings?

_____

_____

_____

What kinds of support does a person receive at home, school, work, and other settings? Do you believe there may be issues related to the number of staff, level of family support, staff or family training needs, or certain types of social interactions that may be related to the person's problem behaviors?

_____

_____

_____

Define specific immediate antecedent events that predict when the behaviors are likely and not likely to occur.

Settings that is most and least likely to trigger problem behavior

Most Likely	*Less Likely*
_____	_____
_____	_____
_____	_____
_____	_____

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 4)

Times that are most and least likely to trigger problem behavior

Most Likely	*Less Likely*

People who are most and least likely to trigger problem behavior

Most Likely	*Less Likely*

Activities that is most and least likely to trigger problem behavior

Most Likely	*Less Likely*

Describe something that you could do or say that almost always results in problem behavior. This may include a certain tone of voice (authoritarian, aloof, overly concerned, etc), particular words or phrases (e.g. "no, that's not right, do it again.")

_____

_____

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 5)

Briefly describe what the person would do in the following situations.

The person is asked to complete a difficult task.

_____

_____

A highly preferred activity naturally ends or is interrupted.

_____

_____

There is a sudden and unexpected change in the person's daily schedule.

_____

_____

A preferred item or activity is visible but the person needs assistance to obtain it.

_____

_____

The person is left alone (e.g., for 15 minutes).

_____

_____

The person is in the room with other people but no one is interacting with him or her.

_____

_____

_____

IDENTIFY THE CONSEQUENCES OR OUTCOMES OF THE PROBLEM BEHAVIORS (WHAT HAPPENS RIGHT AFTER THE BEHAVIOR OCCURS)

Think of each of the behaviors you listed previously, and identify a specific routine (e.g. getting up in the morning, going to the store, etc.). Describe what happens right after the behavior. Does the person obtain something? Does the person escape or avoid something?

Problem Behavior	Routine	*What does the person obtain?*	*What does the person escape or avoid?*
1.			
2.			
3.			
4.			
5.			

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 6)

Positive Behavior	Routine	*What does the person obtain?*	*What does the person escape or avoid?*
1.			
2.			
3.			
4.			
5.			
6.			

CONSIDER HOW MUCH EFFORT IT TAKES TO ENGAGE IN EACH OF THE **PROBLEM AND POSITIVE BEHAVIORS**. THINK ABOUT (A) HOW MUCH PHYSICAL EFFORT IT TAKES TO ENGAGE IN EACH BEHAVIOR, (B) HOW OFTEN A BEHAVIOR OCCURS BEFORE IT IS REINFORCED, AND (C) HOW LONG THE PERSON HAS TO WAIT TO GET THE REINFORCER.

Problem Behaviors	**Low**				**High**
	Effort				*Effort*
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

Positive Behaviors					
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

WHAT *FUNCTIONAL ALTERNATIVE* BEHAVIORS DOES THE PERSON ALREADY KNOW HOW TO DO?

Which socially appropriate behaviors or skills listed previously generate the same outcomes or reinforcers produced by the problem behaviors?

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 7)

HOW DOES THE PERSON COMMUNICATE WITH OTHER INDIVIDUALS?

Describe the most common strategies a person uses express himself and what communication strategies are available to the person. Communication used may involve speech, signs and gestures, communication boards, or electronic devices. Are there any problems with assistive communication systems that are currently being used?

Describe the person's receptive communication skills and ability to understand others.

Can the person follow spoken requests or instructions that are simply stated? Give examples of simple and more complicated, (if applicable), requests or instructions that can be followed.

Does the person seem to understand and respond to requests or instructions that are signed or gestured? Give several examples of signed or gestured instructions that can be followed.

Can person imitate actions if you show the person how to do something? Give several examples of the types of actions that can be imitated.

How does the person typically communicate *yes or no* when given a choice or being told to do something?

DESCRIBE THINGS THAT YOU SHOULD DO AND THAT SHOULD BE AVOIDED WHEN WORKING WITH AND SUPPORTING THIS PERSON.

Describe what you do to improve the likelihood that activities or other things will go well when you are with this person.

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 8)

Describe the things you do to avoid interfering with or disrupting an event or activity when you are with this person.

DESCRIBE THE THINGS THAT THE PERSON LIKES AND FINDS REINFORCING

Favorite foods:

Toys, games, or items:

In-home activities:

Community activities:

Other events, people or activities:

DESCRIBE WHAT YOU KNOW ABOUT THE HISTORY OF PROBLEM BEHAVIORS IDENTIFIED PREVIOUSLY OR OTHER PROBLEM BEHAVIORS THAT NO LONGER ARE PRESENT. INCLUDE INFORMATION ABOUT ANY INTERVENTIONS THAT HAVE BEEN TRIED IN THE PAST AND HOW EFFECTIVE THOSE INTERVENTIONS WERE AT THE TIME.

List past problem behaviors   *Interventions* *Effectiveness*

1.

2.

3.

4.

5.

6.

FUNCTIONAL BEHAVIORAL ASSESSMENT INTERVIEW FORM (P. 9)

7._____

8._____

9._____

10._____

WRITE DOWN HYPOTHESIS STATEMENTS FOR EACH MAJOR TRIGGER AND/OR CONSEQUENCE.

Setting Event	*Immediate Antecedent (Trigger)*	*Problem Behavior*	*Consequence Maintaining*
	—	—	—
	—	—	—
	—	—	—
	—	—	—

Adapted From:

O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior: A practical handbook (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Functional Assessment

Information Gathering Questions

1. What challenging behavior has been identified?

   - What physical signs or actions, cycles or courses does it take?
   - How often does it occur?
   - What is its duration and level of severity?

2. What is the history of the challenging behavior?

   - When did it first appear?
   - What is the course over time (days, weeks, months, years)?
   - Has it recently increased or decreased?
   - What do others view as contributing factors?
   - Have any life experiences affected the behavior?
   - Are there related general medical, neurological, organic or psychiatric concerns that need to be addressed?

3. Are there setting events which may increase the likelihood of that behavior occurring?

   - Medication side effects
   - Deprivation situations
   - Physical ailments
   - Stress
   - Environmental factors
   - Cultural differences
   - Limitations

4. What are possible antecedents for the challenging behavior?

   - What are the settings and situations in which the behavior occurs and doesn't occur?
   - When does the behavior occur and not occur?
   - What happens just before the behavior occurs?
   - What is the quality of communication?
   - Does the person have choices?
   - Is there variety in the daily activities?
   - Are they doing things they find meaningful?

5. What are the consequences of the challenging behavior?

- What interventions were used when the behavior last occurred?
- What interventions have been used by family, support persons or others?
- What effect does this behavior have on others?
- Is the consequence reinforcing the behavior?

6. What is the function of the behavior?

- What purpose does the behavior serve for the person?
- What maintains reinforces or extinguishes the behavior?
- What seems to help relieve the situations?

Service Coordinator Review

Should we intervene?

    Does the behavior present an imminent danger to the person or others?

    Is the behavior intolerable?

Is it the right intervention?

    Does the intervention meet the dignity standard?

    Is the intervention too intrusive for the situation?

    Is it the most positive alternative available?

    Is it the least intrusive intervention possible while still being effective?

Are the person's rights protected?

    Does the intervention, in any way, infringe upon the person's statutory and constitutional rights?

    Has the person been fully informed of what will occur, the benefits and risks involved, and the possible alternative methods of treatment? Based on this information, is the individual, and/or their legal representative, able to provide informed consent for this plan?

    Has the person, and/or their legal representative been given an opportunity to object and to have the matter arbitrated by an impartial and informed arbiter?

    Is information about the person kept confidential?

    Is the intervention working?

    Are emergency strategies being used less frequently?

    Is the person learning alternative skills?

    Are the undesirable behaviors decreasing?

    Does the person seem happier?

    Are there long term prevention strategies in the plan?

Alternative Skills to Be Taught

Functional Equivalence Training:

What is the function of the challenging behavior?

What alternative skills will be taught (remember, alternative skills must serve the same function as the problem behavior)?

How will the alternative skills be taught?

General Skills Training:

What skills deficits are contributing to the problem behavior?

What alternative skills will be taught that will prevent the problem behavior from occurring?

How will the alternative skills be taught?

Self-Regulation Training:

What events appear to be contributing to the person's anger or frustration in reference to the challenging behavior?

What self-control skills will be taught to help the student deal with difficult/frustrating situations?

How will the alternative skills be taught?

LEARNING STYLE PROFILE

Name: _____   Date: _____

Completed by:_____

Each of the following sections presents a number of dimensions known to affect the rate of learning for different individuals. For each item, circle the **one** response that describes the conditions under which **this** individual learns best. Circle "?" if you are unsure; circle "NR" when the condition is not relevant. Upon completion, review all responses and mark the **five** items most critical to the design and delivery of instruction for this individual.

INDIVIDUAL LEARNING STYLE

Critical Items

Preferred mode for processing information - visual / auditory / tactile / combined / ? _____
Preferred position - seated / standing / laying down / varies / ? / NR _____
Previous activity - preceded by physical activity / preceded by a quiet activity / ? / NR _____
Mealtimes - before meal or snack / after meal or snack / ? / NR _____
Time of day - morning / afternoon / evenings / varies / ? / NR _____
Time of the week - early in the week / midweek / late in the week / weekends / ? / NR _____
Most effective type of prompt - physical / visual / verbal / varies / ? _____
Tolerance for prompt fading - requires prolonged use of prompts / moves easily to less
   direct prompting / responds with time delay / varies / ? _____
Response to new situations - looks around / disengages / laughs, cries or vocalizes /
   manipulates materials / engages with people / other _____ / ? _____
Response to inactivity - daydreams / vocalizes / becomes restless / manipulates materials /
   other _____ / ? _____

REINFORCER ASSESSMENT

Preferred type - social / tangible / free time / self-reward / combined / varies / ? _____
Type of social - brief praise / prolonged social contact / physical contact / public posting / varies /
   ? / NR _____
Type of tangible - food / toys / preferred items / clothing / money / privileges / special activities /
   varies / ? / NR _____
Use of free time - break from task / relaxation time / time off / varies / ? / NR _____
Self-reward - pride in accomplishment / engaging in sensory-motivated activities / varies / ? / NR _____
Tolerance for reinforcer fading - requires prolonged, high level of reinforcement / moves to
   intermittent schedules easily / varies / ? _____

INSTRUCTIONAL DESIGN

Group size - 1:1 / small group / large group / varies / ? _____
Style of interaction - friendly or familiar / stern or formal / varies / ? / NR _____
Task variety - single activity at a time / working on variety of tasks / varies / ? / NR _____
Task type - open-ended tasks / tasks with a clear starting and ending point / varies / ? / NR _____
Task familiarity - familiar / new / varies / ? / NR _____
Task difficulty - easy / moderate / difficult / varies / ? / NR _____
Transitions - signalled / occur on schedule without other notice / varies / ? / NR _____
Daily schedule - clearly explained and followed / tolerates changes without notice / varies / ? / NR _____
Activity level during task - stationary / some movement / physically active / ? / NR _____
Length of time on task - <5 minutes / 5-15 minutes / 15-30 minutes / >30 minutes / varies / ? _____

INSTRUCTIONAL SETTING

Noise / activity level - in quiet areas / in active areas / ? / NR _____
Lighting level - in soft, dimly lit areas / in bright, well lit areas / ? / NR _____
Temperature - cool / warm / ? / NR _____
Location - indoors / outdoors / community locations / home / ? / NR _____
Appearance - clean, uncluttered area / "messy", stimulating areas / ? / NR _____

Initial Behavioral and Emotional Symptoms of Sexual Assault

- **Non-contextual fear**

- **Inability to trust**

- **Displaced anger and hostility**

- **Inappropriate sexual behavior**

- **Depression**

- **Guilt or shame**

- **Performance deterioration**

- **Somatic complaints**

- **Sleep disturbances**

- **Eating disorders**

- **Phobic or avoidant behaviors**

- **Regressive behavior**

- **Accident proneness**

- **Runaway behavior**

Long Term Effects of Assault

- **Depression, feelings of isolation, and suicidal behavior**

- **Anxiety as a lifestyle**

- **Negative self-concept**

- **Impaired interpersonal relationships**

- **Vulnerability to re-victimization**

- **Propensity to choose abusive mates**

- **Problems with sexual adjustment**

- **Substance/alcohol abuse**

- **Eating disorders**

- **Post-Traumatic Stress Disorder (PTSD)**

- **Borderline Personality Disorder (BPD)**

- **Dissociative Identity Disorder**

Additional Resources:

PLANNING
- Life Style Planning, O'Brien, 1987; O'Brien & Lyle, 1987
- Personal Futures Planning, Mount, 1987: Mount & Zwernick, 1988
- The McGill Action Planning System, Forest & Lusthaus, 1987
- Framework for Accomplishment/Personal Profile, O'Brien, Mount, & O'Brien, 1991
- Essential Lifestyle Planning, Smull & Harrison, 1992
- PATH: Planning Alternative Tomorrow's With Hope, Perpoint, O'Brien, Forest, 1993
- Individual Service System Design

Associations:
- NADD: A national association about the mental health needs and care for people who have developmental disabilities www.thenadd.org

Journal:
- Mental Health Aspects of Developmental Disabilities www.mhaspectsofdd.com

Websites and Links:
- For free tools, and articles, such as: *Aggression and Self Injury* www.craconferences.com

- Maintained by the Foundation for Gentle Teaching in the Netherlands, but this section is entirely in English. It includes sections on Basic Values. www.companionresources.org/.cWcustom/gentle/index.html

- Over 25 years of accomplishments, struggles, successes and, most of all, discoveries in a book of less than 100 pages. That's the beauty and the power of *Shift Happens* and NO restraints. http://www.shifthappens.tv/home.htm

- DMRDD Person-centered Planning Guidelines: www.dmh.state.mo.us/mrdd/issues/planning/pcpguide11-18.doc